

Second Semi-Annual Report

September 15, 2005

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Second Semi-Annual Report

1. INTRODUCTION

This is the second semi-annual report of the Consultants Committee prepared pursuant to Section F (5) of the Memorandum of Agreement Between the United States Department of Justice and the State of Arizona Concerning Adobe Mountain, Black Canyon, and Catalina Mountain Schools.

This report covers the time period commencing March 15, 2005 through August 15, 2005. The Committee will continue to issue a report every six months. The report is organized into discreet provisions and assigned Unique File Numbers (UFN's). Each consultant's sections can be identified by this numbering system.

The Consultants Committee acknowledges that the agency continues to make significant strides in remedying deficiencies identified in the CRIPA investigation that began in June 2002.

The Consultants Committee also wishes to acknowledge the complete cooperation of the staff of the Arizona Department of Juvenile Corrections. Director Michael Branham has provided to the Committee complete access to all facilities, youth, staff, files and data.

This Second report builds on the recommendations contained in the First Semi-annual Report issued March 15, 2005. In the first reporting period there were some provisions that, due to time constraints, could not be addressed in the time frame allowed. In this Second report all provisions are rated as to compliance status.

At the conclusion of each site visit de-briefings continue to be held with Director Branham and his leadership team. The team has continued to be receptive to recommendations of the Consultants Committee and in many cases instituted remedial measures prior to the termination of the visit.

The state of Arizona, through this settlement agreement, is making significant improvements in its juvenile justice system. Levels of compliance are increasing due both to the cooperation and work of ADJC staff, but also due to the time needed for appropriate responses and monitoring activity to take place. In some instances, in this report, ratings of substantial compliance are not given even though the ADJC has instituted appropriate responses to the UFN. Substantial Compliance to any provision will necessitate a time period in order for the Department to demonstrate not only administrative compliance through policy & procedure development but implementation of those policies & procedures within each facility.

2. DEFINITIONS

Compliance with the Agreement requires that ADJC demonstrate substantial compliance for each of the substantive remedial measures at all three facilities. In this report, the Consultants Committee describes the steps taken by ADJC to implement the remedial measures and the extent to which ADJC has complied with the requirements of the Agreement. In assessing compliance, the Committee utilizes the following terms, which have been agreed upon by the parties:

Substantial Compliance: Substantial compliance with all components of the rated provision. Non-Compliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance will not constitute failure to maintain substantial compliance. At the same time, temporary compliance during a period of sustained non-compliance shall not constitute substantial compliance. A rating of substantial compliance shall not be made unless such rating is applicable to all three facilities.

Partial Compliance: Compliance has been achieved on most of the key components of the Agreement provision at all three facilities, but substantial work remains. A rating of partial compliance shall also be made where one or more facilities are in substantial compliance with a provision, but the other(s) are not in substantial compliance.

Non-Compliance: Non-compliance with most or all of the components of the Agreement requirements at all three facilities.

Not Reviewed: This rating is given if the Consultant's Committee due to time constraints in the initial reporting period could not adequately review it.

The Consultants Committee has collaborated in developing this report but individual consultants have taken primary responsibility for sections of the report:

Lindsay Hayes	Suicide Prevention
Russ Van Vleet	Juvenile Justice
Peter Leone	Special Education
Louis Kraus	Medical Care, Mental Health Care

3. SUICIDE PREVENTION

UFN 3.1 (Training), 3.1.1. The DOJ acknowledges that ADJC has designed and implemented a suicide-prevention training curriculum. ADJC shall continue to conduct suicide prevention training for youth contact staff. Within six months of the effective date of this Agreement, the State shall review and, to the extent necessary, revise its suicide prevention training curriculum, which shall include the following topics:

- (1) (3.1.1.1) the ADJC suicide prevention policy as revised consistent with this Agreement;
- (2) (3.1.1.2) why facility environments may contribute to suicidal behavior;
- (3) (3.1.1.3) potential predisposing factors to suicide;
- (4) (3.1.1.4) high risk suicide periods;
- (5) (3.1.1.5) warning signs and symptoms of suicidal behavior;
- (6) (3.1.1.6) case studies of recent suicides and serious suicide attempts;
- (7) (3.1.1.7) mock demonstrations regarding the proper response to a suicide attempt; and
- (8) (3.1.1.8) the proper use of emergency equipment.

Status: Substantial Compliance

Discussion: The 8-hour Suicide Prevention Pre-Service Training Curriculum has been recently revised and a 4-hour *Suicide Prevention Refresher and Update 2005* developed. (It should be note that the previous refresher training had been 2 hours in length.) Both curricula were revised and/or developed based upon the recommendations contained in the Consultants Committee's March 2005 report and now include topics 1 through 8 above. Overall, both curricula are excellent and the Committee commends the ADJC for its efforts in developing a comprehensive suicide prevention program, as well as expanding the refresher training.

Recommendation: One minor recommendation is offered. Both curricula suggest that the three prior ADJC suicides occurred between October 2001 and June 2002. In fact, these deaths occurred between April 2002 and March 2003. The *Suicide Prevention Pre-Service Training Curriculum* (at pages 3 and 29) and *Suicide Prevention Refresher and Update 2005* (at pages 4 and 21) need to be revised.

Documentation: *Suicide Prevention Pre-Service Training Curriculum; Suicide Prevention Refresher and Update*

UFN 3.1 (Training), 3.1.2. Within six months of the effective date of this Agreement, the State shall ensure that all existing and newly hired direct care, medical, and mental health staff, receive an initial eight-hour training on suicide prevention curriculum described in paragraph (1) above. Following completion of the initial training, the State shall ensure that two hours of refresher training on the curriculum are completed by all direct care, medical and mental health staff each year.

Status: Substantial Compliance

Discussion: Beginning in February 2003, the ADJC began offering an 8-hour suicide prevention training curriculum to all agency employees, including direct care, medical, mental health, and education staff. As of July 29, 2005, 92% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 8-hour suicide prevention workshop, including 97% of direct care (including mental health) personnel, 73% of medical staff, and 71% of education staff. It is noteworthy to report that *only* 60 of 770 direct care staff at these facilities did not complete the workshop. The high compliance rate for direct care staff is very impressive.

Beginning in October 2003, ADJC began offering a 2-hour suicide prevention *update* training curriculum to all agency employees, including direct care, medical, mental health, and education staff. As noted above, this refresher training has since been expanded a 4-hour program. As of July 29, 2005, 91% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 4-hour suicide prevention workshop, including 92% of direct care (including mental health) personnel, 86% of medical staff, and 83% of education staff. It is noteworthy to acknowledge that 100% of all BCS personnel [direct care (including mental health), medical, and education staff] have completed the annual refresher training.

It should also be noted that AMS has recently hired private security personnel to perform constant supervision of youth housed in the Separation Unit on suicide precautions. Although the Consultants Committee observed that these personnel were interacting appropriately with suicidal youth, they have not received any suicide prevention training.

Recommendations: First, with the exception of BCS, medical and education personnel in both AMS and CMS continue to have compliance rates that are below direct care staff. For example, only 78% of medical and 76% of education staff have received annual suicide prevention training at AMS. It is strongly recommended that ADJC continue to strive to ensure that medical and education personnel achieve higher completion rates for both pre-service and annual refresher training. Second, it is strongly recommended that any private security personnel hired by ADJC to have regular contact with youth be required to complete, at a minimum, the 4-hour suicide prevention refresher training.

Documentation: *Suicide Prevention and Suicide Prevention Update Compliance Report* (thru July 29, 2005).

UFN 3.2 (Identification/Screening), 3.2.1. The DOJ acknowledges that the State has extensively revised its suicide prevention policies and procedures. Within six months of the effective date of this Agreement, the State shall revise its suicide prevention policy to reflect that any staff member who observes and/or identifies a youth as potentially suicidal shall immediately place the youth on suicide precautions and refer them to a qualified mental health professional for assessment.

Status: Substantial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. The Consultants Committee found that current practices indicate that ADJC staff consistently notifies either the unit manager or officer-

in-charge when they observe and/or identify a potentially suicidal youth. The youth is then placed on suicide precautions and referred to QMHP staff. The newly revised policy reflects this practice.
Recommendation: None
Documentation: ADJC <i>Policy 4250.01</i>
UFN 3.2 (Identification/Screening), 3.2.2. The State shall continue to ensure that any staff member who places a youth on suicide precaution shall document the initiation of the precautions level of observation, housing location, and conditions of the precautions.
Status: Substantial Compliance
Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. The Consultants Committee found that current practices indicate that, following the placement of a youth on suicide precautions, a Suicide Prevention Time Sheet is initiated and includes the youth's name, "K" number, time and date, level of observation, special instructions, and document time intervals of observation. Within 24 hours of placement on suicide precautions, the youth's name will be appearing on the facility's Daily Suicide Prevention Status List. This document, initiated by the facility psychologist, includes the youth's name, assigned housing unit, and "K" number, level of observation, reason and start date for suicide precautions. The newly revised policy reflects this practice.
Recommendation: None
Documentation: ADJC <i>Policy 4250.01; Suicide Prevention Time Sheet; Daily Suicide Prevention Status List</i>
UFN 3.2 (Identification/Screening), 3.2.3. The State shall continue to develop and implement policies and procedures to ensure that the documentation described in paragraph (b) above is provided to mental health staff and that in-person contact is made with mental health staff to alert them of the placement of a youth on suicide precaution.
Status: Substantial Compliance
Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. The Consultants Committee found that existing practices indicate that the documentation described in paragraph (b) above is provided to QMHP staff and that the appropriate QMHP staff member is notified of the youth's placement on suicide precautions. The newly revised policy reflects this practice.
Recommendation: None
Documentation: ADJC <i>Policy 4250.01</i>

UFN 3.2 (Identification/Screening), 3.2.4. The State shall continue to ensure that a formalized suicide risk assessment by a qualified mental health professional is performed within an appropriate time not to exceed 24 hours of the initiation of suicide precautions.

Status: Substantial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. Several of the Consultants Committee's recommendations were incorporated into the revised policy. ADJC currently utilizes several suicide risk assessment instruments at two points during a youth's confinement: 1) upon entry into the ADJC's Reception and Classification (RAC) units, and 2) upon observation and/or identification of suicidal behavior. Almost immediately upon entry into a RAC unit, several intake screening instruments are administered, including the Massachusetts Youth Screening Instrument (MAYSI), the Initial Precautionary Risk Assessment, Mental Status Exam Checklist, and CAPFA Domain 2 Behavioral Health-Mental section. The MAYSI is administered to the youth by a non-QMHP staff, but scored by QMHP staff, whereas the Initial Precautionary Risk Assessment, Mental Status Exam Checklist, and CAPFA Domain 2 Behavioral Health-Mental are administered to the youth by QMHP staff. In addition, any time a youth is either observed and/or identified as being potentially suicidal; the youth is assessed by QMHP staff utilizing a Crisis Intervention Assessment (CIA) form. The CIA form contains the youth's name, "K" number, housing unit, date and time of assessment, QMHP staff performing the assessment, self-reported behavior, findings/observations, mental status exam, assessment, recommended suicide observation level, and plan. The Consultants Committee found that the CIA form is always administered well within 24 hours of the youth being initially identified and/or observed displaying potentially suicidal behavior.

Overall, the Consultants Committee continued to find very good practices regarding the identification of suicidal youth through the suicide assessment process.

Recommendation: As offered in our March 2005 report, current policy (4203.01) requires that the MAYSI is administered to all new youth (including parole violators) within an hour of arrival at an ADJC facility. In CMS, new youth committed to the ADJC from surrounding juvenile courts arrive at the facility on Tuesday and Thursday mornings awaiting transfer to the RAC units at either AMS or BCS. Although these youth are only in CMS for up to a few hours (and either kept in the lobby or the Separation Unit) and receive initial health screening by the medical staff, they are also subjected to the MAYSI screening. In addition, as a result of this screening, QMHP staff at CMS often receive computer-generated e-mail notifications regarding the youth's MAYSI scoring several days later even though the youth has since been transferred out of the facility. This practice appears both counter-productive and time-consuming for QMHP staff at CMS, and it would appear more appropriate to conduct the MAYSI screening once the youth arrives at the designated RAC unit.

Documentation: ADJC Policy 4250.01, Policy 4203.01; *Massachusetts Youth Screening Instrument (MAYSI)*; the *Initial Precautionary Risk Assessment*; *Mental Status Exam Checklist*; and *CAPFA Domain 2 Behavioral Health-Mental* section; interviews with CMS QMHP Staff

<p>UFN 3.2 (Identification/Screening), 3.2.5. The State shall continue to ensure that mental health staff thoroughly reviews a youth's clinical and master files for documentation of any prior suicidal behavior.</p>
<p>Status: Partial Compliance</p>
<p>Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. Notwithstanding the newly revised policy, the Consultants Committee continues to have concerns that existing practices indicate that QMHP staff do <u>not</u> consistently review either the clinical (health care) or master (field) files for documentation of any suicidal behavior. There are several reasons for this inconsistency.</p> <p><u>First</u>, medical and mental health records are still <u>not</u> fully integrated into a health care file (see 3.2.8 below for further discussion), resulting in psychological and/or community mental health records being filed in a youth's field file and not reviewed by QMHP staff.</p> <p><u>Second</u>, several QMHP staff still acknowledged that they do not routinely access either the youth's health care or field files, nor the Youthbase management information system. One veteran QMHP told the Committee that "I keep my own file system and will never walk over to the medical unit (to review the integrated file system when it is completed). There's nothing in those files that I need."</p> <p><u>Third</u>, as discussed below in 3.2.8, not all pertinent records are contained within the health care file and some QMHP staff are not computer savvy and do not access their e-mail and other computer programs on a regular basis.</p> <p><u>Fourth</u>, as discussed below in 3.2.7, the ADJC still does <u>not</u> receive pertinent medical and/or mental health records from Superior Courts and county juvenile detention facilities in a timely fashion, therefore records that could be reviewed by QMHP staff are not.</p> <p><u>Fifth</u>, there has been a significant turnover in QMHP personnel during the past few months, as well as several vacancies, particularly at CMS. As such, existing QMHP staff report that they simply do not have the time to thoroughly review case files.</p> <p>In conclusion, a rating of partial compliance is given because of these continued and troubling practices.</p>
<p>Recommendation : Although the Consultants Committee is hopeful that, once the integrated file system is complete and existing vacancies are filled, QMHP staff will be in a better position to thoroughly review clinical files, it is strongly recommended that the Quality Assurance Administrator begin to audit QMHP compliance with 3.2.5.</p>
<p>Documentation: ADJC <i>Policy 4250.01</i>; interviews with AMS and CMS QMHP staff</p>
<p>UFN 3.2 (Identification/Screening), 3.2.6. The State shall continue to ensure that newly arrived residents are placed under close observation until they can be assessed by mental health</p>

staff.
Status: Substantial Compliance
Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. The Consultants Committee continues to find that existing practices indicate that newly arrived youth remain under visual observation of direct care staff until they are assessed by QMHP within one hour of their arrival at the designated RAC unit. The newly revised policy reflects this practice.
Recommendation: None
Documentation: ADJC <i>Policy 4250.01</i>
UFN 3.2 (Identification/Screening), 3.2.7. The State shall develop and implement policies and procedures to expeditiously obtain from the juvenile divisions of all Superior Courts in the state, as well as all county juvenile detention facilities and/or placement settings from which the youth is committed, all pertinent records with the youth upon commitment to ADJC within one week of the youth's arrival.
Status: Partial Compliance
<p>Discussion: ADJC entered into a Memorandum of Agreement (MOU) with the Administrative Office of the Courts concerning the timely transfer of pertinent information on youth committed to the agency from local juvenile courts throughout the state. Effective April 2005, the agreement requires that juvenile courts submit these pertinent records within seven (7) days of the youth's arrival to ADJC. A <i>Checklist for Juvenile Commitment to ADJC</i> was developed, and includes, but is not limited to, the requirement for juvenile courts to forward "documentation of any suicidal behavior or ideation" and "psychological and psychiatric reports, including mental health treatment summaries." Although local court systems are allowed up to 7 days to submit this information, the records are ideally transferred with the youth upon their arrival at the ADJC's RAC unit.</p> <p>The Consultants Committee reviewed the requirements of 3.2.7 at BCS on both April 28 and August 4, 2005. Coincidentally, the reviewed records concerned youth transferred from the Maricopa County juvenile court system. During the April review, the Committee reviewed the files of T.L. who arrived at BCS on April 28. T.L. had an extensive mental health and suicidal behavior history. This history was reflected in the probation officer's disposition report. The juvenile detention records were limited to a "Transfer Summary" sheet and "Health Appraisal" form. Neither form contained pertinent information regarding her extensive mental health and suicidal behavior history. (The Consultants Committee could not locate a <i>Checklist for Juvenile Commitment to ADJC</i> in the file.) However, upon T.L.'s entry into BCS, the mental health records reflected in the probation officer's disposition report were immediately placed in her field file, and not reviewed by either medical or mental health staff. Fortunately in this case, T.L. was very forthcoming about her history (including the death of her mother three weeks earlier) with the QMHP who conducted the initial assessment, and the youth was placed on</p>

suicide precautions. Upon returning in August, the Consultants Committee again reviewed T.L.'s file and found that she had been placed on suicide precautions (and even hospitalized) on numerous occasions during the past few months. However, both her medical and mental files were complete, and T.L. had been provided regular and well documented care by the facility psychiatrist. It would be the Committee's assumption that, with the newly revised integrated file system (see 3.2.8); a newly arrived youth's mental health file will now be placed in their ADJC mental health file, and not the field file. QMHP staff would then be required to review the file within 8 hours.

During the August 4 visit, the Consultants Committee also reviewed the files of three youth who arrived at BCS from Maricopa County on July 28. Each of the three youth (G.C., C.T. and E.T.) had completed "Transfer Summary" and "Health Appraisal" forms from Maricopa County. Each "Transfer Summary" form was unremarkable for mental health, and had "psychiatric history: none" circled. Strangely, however, each of the three girls arrived at BCS with psychotropic medication. The Consultants Committee also could not locate a *Checklist for Juvenile Commitment to ADJC* in the files of any of the three youth. Each of the youth were subsequently interviewed by BCS medical and mental health staff, including the facility psychiatrist. Two of the youth (G.C. and E.T.) had histories of suicidal behavior/ideation, and one (G.C.) was placed on suicide precautions following an elevated MAYSI score. The facility psychiatrist wrote a physician's order in each of the medical files on July 28 to "Please obtain psy. Records from detention." As of August 4, no such records had arrived from Maricopa County. Although subsequent follow-up determined that each of the youth was apparently receiving psychotropic medication from a community provider(s), there was no indication whatsoever as to whether any of the youth had mental health and/or suicidal ideation problems while in detention. It would appear to the Consultants Committee that the MOU was violated by Maricopa County in each of these three cases.

Finally, the Consultants Committee also reviewed the case of T.C. a parole violator who arrived at AMS on July 7, 2005. Although this case will be discussed in more detail in 3.6.1 below, T.C. had a significant mental health history, yet the ADJC parole officer did not return the field file back to AMS until 12 days later on July 19, 2005. The file contained significant information that could have been helpful to QMHP staff. It should also be noted that QMHP staff at AMS never requested the file, presumably because current practice is for the field file to be requested following the youth's parole hearing (usually conducted within 30 days).

Recommendation: As stated in the March 2005 report, the incomplete transfer and/or review of pertinent information from local juvenile courts to ADJC was a central issue in at least one of the ADJC suicides. The Consultants Committee would again reiterate the importance of local juvenile courts to fully comply with the MOU, and strongly recommend that the Quality Assurance Administrator begin to audit compliance with 3.2.7.

In addition, given the fact that ADJC entered into a MOU with the Administrative Office of the Courts to transfer pertinent records regarding the youth within 7 days, it is prudent for ADJC to require its parole officers to return a youth's field file as quickly as possible, and certainly within the timeframe required by outside agencies.

<p>Documentation: <i>Memorandum of Agreement Between the Administrative Office of the Courts and the Arizona Department of Juvenile Corrections; Checklist for Juvenile Commitment to ADJC; Maricopa County juvenile records for T.L., G.C, C.T., and E.T.; ADJC's field files, medical files, mental health files and red folders for T.C., T.L., G.C, C.T., and E.T.; interviews with BCS medical and QMHP staff; debriefing with ADJC Director and ADJC Deputy Director; communication with ADJC Communications and Legislation Coordinator</i></p>
<p>UFN 3.2 (Identification/Screening), 3.2.8. The State shall develop and implement policies and procedures to ensure that ADJC creates an integrated medical and mental health record system for each youth. The State shall promulgate a policy requiring that all ADJC mental health staff shall be required to utilize progress notes to document each interaction and/or assessment of suicidal youth.</p>
<p>Status: Partial Compliance</p>
<p>Discussion: ADJC has developed a Maintenance of the Mental Health Records policy (1120) that specifies the documents (including the IPRA and CIA) to be included in each youth's mental health file. Due to liability concerns among some ADJC officials, the mental health and medical records will not be fully integrated. Current plans are to physically place the mental health records in a separate file cabinet next to the health care files in each facility's medical unit. Most importantly, mental health records, most of which are confidential, are in the process of being removed from the field files and relocated into newly created mental health files for each youth. As of August 5, the project had not been completed, thus a rating of Partial Compliance is given. It should also be noted that the Consultants Committee noticed an improvement in completion of progress notes (i.e., CIA forms) by QMHP staff.</p>
<p>Recommendation: The intent of 3.2.8 in the Compliance Agreement was that an integrated mental health and medical file would better ensure effective communication amongst QMHP and medical staff regarding the management of suicidal youth. Now that the file system will not be fully integrated, rather simply coexisting alongside each other, it will still be necessary for ADJC to ensure that both medical and QMHP staff access both files when appropriate.</p>
<p>Documentation: <i>ADJC Policy 1120</i></p>
<p>UFN 3.2 (Identification/Screening), 3.2.9. The State shall continue to develop, implement, and comply with policies and procedures for communicating the management needs of suicidal youth among direct care, medical, and mental health personnel.</p>
<p>Status: Substantial Compliance</p>
<p>Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. The Consultants Committee found that existing practices indicate clinical team meetings occur on a regular weekly basis at each facility, and these meetings consistently include psychology associates, psychologists, and psychiatrists. The management and treatment plan needs of each youth on suicide precautions are discussed during these weekly meetings. The Consultants Committee found this to be an excellent</p>

practice. The Committee attended a clinical team meeting at AMS on August 3 and was very impressed by the fact that most QMHP staff had a very good working knowledge of each youth being discussed.

ADJC has corrected a previous concern by the Consultants Committee that medical personnel were not consistently aware of which youth were on suicide precautions on a daily basis. A hard copy of the Daily Suicide Prevention Status List is now generated and kept in the Medical Unit in each facility.

Recommendation: None

Documentation: ADJC *Policy 4250.01*; *Daily Suicide Prevention Status List*; interview with AMS Clinical Team

UFN 3.3 (Safe Housing of Suicidal Youth), 3.3.1. The DOJ acknowledges that the State has taken significant steps to remedy physical plant hazards to suicidal youth. The State shall continue its remedial plans to ensure that all youth placed on suicide precaution are housed in suicide-resistant rooms (i.e., rooms without protrusions that would enable youth to hang themselves).

Status: Substantial Compliance

Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. As stated in the March 2005 report, ADJC has expended significant resources to ensure that rooms housing suicidal youth are as “suicide-resistant” as possible.

Specifically, all housing unit (3 buildings) renovations at BCS have been completed. In addition, the Consultants Committee was informed that all housing unit (6 buildings) renovations at CMS will be completed by March 2006. CMS is in the process of completing vent replacements. S-Vents are being ordered with an estimated delivery date of November 2005. Once the vents have been replaced, all housing unit renovations will be completed at CMS.

Renovation work at AMS was initiated in April 2003. As of August 2005, 7 of the 12 housing units had completed substantial renovations. During the initial renovations, it was determined that the current shower rooms did not pose a significant risk of self-harm. Since that time, however, based on additional inspection, as well as the fact that the rooms are occasionally left unlocked, it was determined that the shower rooms needed to be renovated. Specifically, the shower heads and vents need to be replaced. In addition, although the door hinges “bevel-down” to thwart against use as an anchoring device, youth have been able to hang laundry bag strings from the hinges. As a result, a protective cover as been designed and will be placed over the hinges. The initial 7 buildings will have these modifications completed by June 2006. The two south buildings (Crossroads and Journey) will also be renovated in the next several months. By June 2006, 9 of the 12 buildings will be completely renovated. The Consultants Committee was informed that, contingent upon funding appropriated for FY 2007, the renovation of the final 3 buildings will be completed by June 2007.

Recommendation: None
Documentation: ADJC <i>Policy 4250.01</i> ; debriefing with ADJC Assistant Director, Legal Systems
UFN 3.3 (Safe Housing of Suicidal Youth), 3.3.2. The State now requires that all direct care staff carry packs on their person containing extraction tools and CPR micro shields. The State shall continue to ensure that direct care staff has immediate access to appropriate equipment to intervene in the event of an attempted suicide.
Status: Substantial Compliance
Discussion: ADJC has revised the policy regarding the Use of Rescue Kits (No. 4250.02) that adequately covers the requirements of 3.3.2. The policy was approved and implemented on April 6, 2005. The Consultants Committee observed that most, if not, all direct care staff in each facility carried a rescue kit pouch that contained a micro shield, latex gloves, and a 911 extraction tool.
Recommendation: None
Documentation: ADJC <i>Policy 4250.02</i>
UFN 3.4 (Supervision), 3.4.1. The State shall develop and implement a “step-down” level of observation whereby youth on suicide precaution are released gradually from more restrictive levels of supervision to less restrictive levels for an appropriate period of time prior to their discharge from suicide precaution.
Status: Substantial Compliance
Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. The policy addresses the steps to be taken in reducing the suicide precaution level of suicidal youth. Overall, the Consultants Committee found that current practices are consistent with this policy.
Recommendation: None
Documentation: ADJC <i>Policy 4250.01</i>
UFN 3.4 (Supervision), 3.4.2. The State shall ensure that all youth discharged from suicide precaution continue to receive mental health treatment in accordance with a treatment plan developed by a qualified mental health professional.
Status: Partial Compliance
Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. Section 5 of 4250.01 requires QMHP

staff to “Note treatment follow-up and recommendations on the CIA form whenever juvenile is downgraded or is removed from precautionary status; ensure treatment follow-up and recommendations are viewed and discussed at each weekly clinical meeting; and ensure that the juvenile’s case plan includes goals and objectives pertaining to suicide prevention and/or self-injurious behavior.”

Current practice is for suicidal youth to be downgraded to Level 4 prior to being discharged from suicide precautions. In addition, Level 4 youth remain on the Daily Suicide Prevention Status List until their case is discussed at the weekly clinical team meetings. As previously stated, this is an excellent practice.

However, when attending a clinical team meeting at AMS on August 3, the Consultant Committee observed that although each of youth on the Daily Suicide Prevention Status List was discussed by the clinical team and each of the Level 4 youth was discharged from suicide precautions, there were few follow-up recommendations or any semblance of treatment plans discussed, nor notations placed in any of the youth’s case files. Although the Committee was told that a youth’s treatment plan would normally be discussed during the monthly multidisciplinary team’s case planning meetings, we were also informed that such meetings have not yet been fully initiated.

In addition, when reviewing a case file from a youth (N.W.) recently discharged from suicide precautions at CMS, the CIA simply read, and “Continue to provide support as needed.” The Consultants Committee does not consider such an entry to be an acceptable treatment plan. In another case at CMS, youth J.M. was completely removed from suicide precautions on July 21 (from Level 3) without being downgraded to Level 4 and maintained on the Daily Suicide Prevention Status List until discussed at the next weekly clinical meeting. As of August 2, he had not been seen again by QMHP staff.

Finally, the Consultants Committee believes it noteworthy to mention there appears to be a dramatic decrease in the number of CMS youth on suicide precautions. For example, during a Consultants Committee visit to CMS on October 20, 2004, there were 4 youth on suicide precautions (3 on Level 3 and 1 on Level 2). During a visit to CMS on February 1, there were 4 youth on suicide precautions (all on Level 3). However, during a visit on August 2, there were no youth on suicide precautions, and the last CMS youth on either Level 1-3 at the facility was July 22 -- a period of 11 days. The Consultants Committee is unsure what to make of this situation. It could be an aberration or result of other factors (e.g., decreased QMHP staff), but we will monitor the issue during up-coming visits.

Recommendations: First, for each youth discussed during a weekly clinical team meeting, there should be a brief progress note recorded in their mental health file which summarizes the discussion. Second, in order to ensure compliance with 3.4.2, ADJC must develop a treatment plan for each youth discharged from suicide precautions.

Documentation: ADJC *Policy 4250.01*; *Daily Suicide Prevention Status Lists* from AMS, BCS, and CMS; ADJC’s medical and mental health files for N.W. and J.M.; interview with AMS Clinical Team

<p>UFN 3.5 (Intervention), 3.5.1. The State has revised ADJC’s suicide prevention policy to specify the proper role of staff in responding to a suicide attempt by youth and shall continue to ensure that staff are trained in appropriate response techniques and the use of emergency equipment on an annual basis.</p>
<p>Status: Substantial Compliance</p>
<p>Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. As of July 29, 2005, 74% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 4-hour <u>CPR</u> workshop, including 78% of direct care (including mental health) personnel, 77% of medical staff, and 44% of education staff.</p> <p>In addition, 75% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the 1-hour <u>Extraction Knife Training</u> workshop (see Section 3.1.1.8 which requires training on “the proper use of emergency equipment”), including 83% of direct care (including mental health) personnel, 38% of medical staff, and 42% of education staff. ADJC also started <u>refresher</u> Extraction Knife Training earlier this year. To date, 88% of all ADJC staff working at AMS, BCS, CMS, and EPS had received the training, including 92% of direct care (including mental health) personnel, 71% of medical staff, and 74% of education staff.</p> <p>As discussed in Section 3.1, the Compliance Agreement requires that all staff receive basic and annual training in “mock demonstrations regarding the proper response to a suicide attempt” (3.1.1.7). The Consultants Committee was informed that the refresher Extraction Knife Training is now incorporated into the <i>Suicide Prevention Refresher and Update 2005</i> and includes presentation of mock drill demonstrations of suicide attempts.</p>
<p>Recommendation: It is strongly recommended that compliance rates be increased for both medical and education personnel in the areas of CPR and Extraction Knife Training.</p>
<p>Documentation: ADJC <i>Policy 4250.01; Suicide Prevention and Suicide Prevention Update Compliance Report</i> (thru July 29, 2005); <i>Suicide Prevention Refresher and Update 2005</i></p>
<p>UFN 3.6 (Mortality Review), 3.6.1. The State shall continue to ensure that all completed suicides and serious suicide attempts are reviewed by the Internal Review Committee for policy and training implications.</p>
<p>Status: Partial Compliance</p>
<p>Discussion: ADJC has extensively revised its suicide prevention policy (No. 4250.01) and the policy was approved and implemented on April 6, 2005. There are two layers of ADJC review following a completed or serious suicide attempt -- critical incident debriefing (1190.02) and internal review committee (4250.03).</p> <p>The <u>Critical Incident Debriefing</u> is a multidisciplinary review at the facility level and involves: “1) a review of the circumstances surrounding the incident; 2) the effect of the incident on</p>

involved employees and juveniles; 3) the cause or potential causes of the incident; 4) identification of known or potential deficiencies in operational procedures and/or practices including circumstances leading up to the incident, response to the incident, and follow-up and notification after the incident; 5) need for immediate corrective action and steps taken; 6) specific employee training issues; 7) review of other options that were possibly available in resolving the incident; 8) identification of appropriate and/or extraordinary responses by employees or juveniles; and 9) assignments and delegation of report writing, including incident reports, and investigations, interviews, etc.”

The Internal Review Committee is a multidisciplinary review at the central office level that is chaired by the Quality Assurance Administrator and includes critical review of: “1) the circumstances surrounding the incident; 2) the facility or community procedures relevant to the incident; 3) any Incident Debriefing Reports; 4) all relevant training received by involved employees; 5) all pertinent supervision and treatment plan reports; 6) all pertinent medical and mental health services/reports involving the victim; 7) pertinent family dynamics; and 8) recommendations for possible improvements in employee training, operational procedures, physical plant, and program services.

The Consultants Committee attended a Critical Incident Debriefing at AMS on August 3 regarding a serious suicide attempt. The case involved a youth (T.C.) who was returned to AMS as a parole violator on July 7, 2005. On August 2, he began to engage in self-harm and was placed on Level 1 suicide precautions in the Separation Unit. T.C. continued to engage in self-harm and was briefly placed in the restraint chair. By the following day (August 3), he was still engaging in self-harm. During the Critical Incident Debriefing session, it appeared to the Consultants Committee that the meeting was more of an opportunity to determine how T.C. was able to continue engaging in self-harm while on Level 1, as well as how to best manage the youth in the foreseeable future. Until the Consultants Committee began to be involved in the discussion, the Critical Incident Debriefing meeting was not addressing most of the above issues that the committee was charted to discuss.

There were several disturbing issues involving T.C.’s case that should have been discussed by the committee. For example, only limited mental health records were available and brought to the meeting. These records, including the MAYSI, Initial Precautionary Risk Assessment, Crisis Intervention Assessment, and CAPFA Domain 2 Behavioral Health-Mental section, were scattered in T.C.’s medical, mental health, and field files, and red folder -- with no file containing a complete picture of the youth’s mental health issues. T.C. had an extensive mental health history, including a six-month commitment (from AMS) to the state hospital in 2004. Although T.C. had arrived at AMS on July 8, the parole officer did not forward the field file (containing some of the state hospital records) to AMS until July 19, nor did any QMHP staff request it or the state hospital records. Further, the treating psychiatrist was unaware that T.C. had recently spent six months in the state hospital, appeared curious to review the state hospital records, and apparently had only reviewed his AMS medical file, and not the field file or AMS mental health file or red folder.

While the immediate management of T.C.’s self-injurious behavior should have certainly been the primary concern of AMS officials and staff on August 3, this session was not a Critical

<p>Incident Debriefing as defined in policy 1190.02.</p> <p>Finally, the Consultants Committee requested samples of any Critical Incident Debriefing that have been completed at any of the facilities. The requested reports were not received in time to be included within this report.</p> <p>The Consultants Committee was also informed that ADJC had not yet conducted reviews of any serious suicide attempts through the Internal Review Committee process.</p> <p>In conclusion, compliance with 3.6.1 is disappointing and a rating of Non-Compliance would have been given if ADJC had not developed and approved the mortality review policy.</p>
<p>Recommendation: It is strongly recommended that ADJC immediately begin to conduct both Critical Incident Debriefings and Internal Review Committees as required by policy. Following these reviews, copies of any generated reports should be forwarded to the Consultants Committee.</p>
<p>Documentation: ADJC <i>Policy 4250.03</i>, <i>Policy 1190.02</i>; ADJC's field, medical, and mental health files, and red folder for T.C.; interview with AMS Critical Incident Debriefing committee; debriefing with ADJC Director and ADJC Deputy Director; communication with ADJC CRIPA Program Administrator and ADJC Medical and Behavioral Health Program Administrator</p>

4. JUVENILE JUSTICE

<p>4.1 Grievance System</p>
<p>UFN 4.1.1 Upon the effective date of this Agreement, the State shall provide youths with an effective, reliable process to raise grievances without exposing them to retribution from staff. The State shall:</p>
<p>Status: Partial Compliance</p>
<p>Discussion: The ADJC grievance system outlined in Policy 2304 and Procedure 2304.1 has been amended in response to the first Monitoring report. Specifically section 10 f was amended to require that the juvenile ombuds attend all meetings involving juveniles and grievance resolutions and recommend possible solutions to grievances. Form 2304.01A has been developed which requires the signatures of the juvenile and the juvenile ombuds. It also provides an opportunity for the juvenile to indicate acceptance or rejection of the grievance solution presented at the resolution meeting. In addition, Form 2304.01B has been developed which tracks the status and progress of each grievance through the process. The grievance process as described by Sheila Press is as follows. At the beginning of each month the juvenile ombuds gives the grievance coordinator a quantity of grievances that are pre-numbered. The juvenile ombuds collects them at least 4 times per week, checking the log to make sure every grievance handed out is returned. If it is not returned the juvenile ombuds goes to the youth to determine</p>

why the grievance was not submitted. Sheila Press then audits the log the grievance coordinator uses in order to check the status of all grievances. On a weekly basis all grievances, due to the numbering system, can be accounted for. Form 2304.01A is filled out at the resolution meeting indicating the ombuds attendance and the resolution of the grievance. There were four issues, in this area, identified in the first report that ADJC has responded to: (1) The reluctance of some staff to accept the grievance process and the role of the juvenile ombuds. The overall acceptance of the process by staff is still not completely known but staff interviewed indicated general acceptance of the rights of youth to grieve. (2) In some instances youth were denied grievance forms. This has been resolved by numbering the forms, as was recommended in the previous report, and assigning forms to a grievance coordinator. This way each month all grievance forms can be accounted for. (3) Juvenile ombuds were not being invited to participate in management meetings. Juvenile ombuds at all three facilities indicated that they are not only attending grievance resolution meetings but also are active participants in management meetings. (4) The de-briefings or resolution meetings were not taking place and often the resolutions were not known to the ombuds. This has changed as noted above. In addition the first report noted the number of grievances that were pending or not resolved and recommended that these grievances be resolved. In a meeting with Lou Goodman and Sheila Press on 5/26/05 it was reported that the backlog of grievances was eliminated and that grievances are now being handled as they occur with the longest one during this last period lasting 33 days for resolution. During the July site visit this list was now down to only 3 grievances pending resolution. During the July visit youth were once again interviewed to determine knowledge of and access to the grievance process. The responses obtained were not significantly different that those received during the first reporting period. In discussing this with staff it is clear that youth are receiving instruction during the RAC process but not retaining that information several weeks or months later when they may wish to file a grievance. To try to remedy this youth are being trained monthly by the juvenile ombuds in each facility. These staff go cottage to cottage and refresh the youth on the grievance procedures. It is anticipated that the youth handbook, which was being distributed to the youth, during this visit, will remedy this situation. Each youth will have a handbook that they will retain in their rooms and can reference as needed. This will be monitored during the next reporting period. The management portion of the grievance process is impressive. The policy and procedure should be sufficient to insure that youth can grieve and that resolutions are equitable and timely. There continues to be some disconnect between the P&P and the actual implementation that needs the handbook distribution, time and monitoring to fully remedy.

Recommendation: Complete the distribution of the handbook and continue the careful monitoring of the process that has been developed by Sheila Press and the Legal Systems Division of ADJC.

Documentation: Meeting held with Lou Goodman, Assistant Director, Legal Division and Sheila Press, Director of the Youth Rights Office during the May and July site visits. Youthbase was accessed and grievances tracked for resolution. The youth Ombuds were interviewed at all three facilities.

UFN 4.1.1.1 Ensure that at the time of orientation, newly arrived youths receive a clear explanation of the grievance process, and that youths' understanding of the process is at least verbally verified.

Status: Partial Compliance

Discussion: The handbook was distributed during the July site visit. A copy was sent to my office in June for my review and a final sent July 7, 2005. The contents of the handbook were found to be comprehensive and encompassing all of the necessary information for youth to be fully oriented to their commitment to ADJC. During this last reporting period youth were interviewed to determine their understanding of and response to the grievance process. During each site visit in May and July youth were interviewed to continue trying to determine how well youth are oriented to the grievance process and to what extent it works. (see 4.1.1) At CMS four youth were interviewed during the May site visit. The first youth knew how to get a grievance form, but had not had a formal orientation. He indicated that he learned of the grievance process from other youth at his cottage, not from the orientation. He claimed to have not understood the grievance process until the last several months when he felt the need to file a complaint. This youth was just completing one year at the facility. Second youth: This youth described the filing of a grievance that involved a confrontation with a security officer. The details of this incident were relayed to I&I for further investigation. This youth confirmed the previous youth's experience of not receiving a formal orientation of the grievance process. Since both of these youth had been at ADJC for one year or longer it was decided to interview two youth who had been recent commitments. Both of these youth indicated that they had received formal orientation to the grievance process at the Reception and Classification Center (RAC). One of the youth claimed to have filed a grievance while at RAC. His complaint was too much time "locked down." According to this youth he received no formal or informal response to his grievance. Attempts to track the grievance found no evidence of a grievance being filed. This youth also claimed to not read well enough to really respond to programming. Something that might have been missed in the RAC process. This information was relayed to ADJC personnel and appropriate steps were immediately taken to assist this youth with his reading skills. In addition to the youth a staff member was selected randomly to interview regarding his understanding of the grievance process. His response was supportive of the grievance process although his understanding of it was considerably different than that provided by the juvenile ombuds at CMS and by Sheila Press and Lou Goodman at the Central Office. During the July visit youth were interviewed at AMS, BCS and all youth in the RAC unit interviewed as a group. The responses from these interviews were not substantially different than those from the May visit and the interviews during the 1st reporting period. On the positive side, the recommendations from the 1st report have been implemented. The handbook has been completed and distributed. The tracking of the orientation process through Youthbase began in June. Youths currently sign rosters indicating they have attended training.

Recommendation: Continue to document through the forms that have been developed the compliance with the current grievance procedures. Begin to establish, through youthbase a comparison of the filing of grievances pre and post handbook distribution.

Documentation: Youth were interviewed at all three facilities. During the May site visit 4 youth were interviewed at CMS. Two were randomly selected and then two identified who had been in custody for more than one year in order to determine if their experience was different than the first two youth who were new commitments. During the July site visit 6 youth were interviewed at AMS and 6 at BCS. In addition, the RAC unit was visited and youth were

interviewed as a group. All of the youth at RAC were included with the group being divided, Al Carpenter interviewing ½ of the group and Russ Van Vleet the other ½. In addition staff at all three facilities were interviewed for their understanding of the grievance process.
UFN 4.1.1.2 Ensure that, without any staff involvement, youths can easily obtain grievance forms and submit grievances directly.
Status: Substantial Compliance
Discussion: As described in earlier sections the grievance process has been modified since the last reporting period to ensure that youth have full access to grievance forms. Grievance coordinators in each cottage have numbered forms and the youth ombuds track these forms so that all are accounted for. In the recommendation section of the last report ADJC was to improve the grievance tracking process and develop a management report. This has been completed and this report allows the tracking of the form, the resolution of the grievance, and the time required. In addition, audits will be performed by legal office staff to ensure that all grievance forms distributed on the units are accounted for. These audits will be conducted on a monthly basis.
Recommendation: ADJC should continue to track the grievance forms and verify that the process is working consistently across each of the facilities. The management reports should be shared with the Consultant quarterly during the next reporting period for evidence of compliance.
Documentation: Meetings with Lou Goodman, Assistant Director, Legal Division and Sheila Press, Director of the Youth Rights Office. Meetings with youth ombuds in each of the facilities. Review of the tracking form through the Youthbase Data System. CRIPA Action Plan submitted on 5/20/05 and effective that date.
UFN 4.1.1.3 Ensure that there are no formal or informal preconditions to the completion and submission of a grievance.
Status: Substantial Compliance
Discussion: The process that has been developed and outlined in 4.1.1 provides that no preconditions currently exist to the filing of a grievance. Previous issues that were identified including staff reluctance to provide forms, destruction of forms, and non-availability of forms, no consistent resolution process, and lack of advocacy in that process have been remedied during this last reporting period. The recommendation from the 1 st Report that the forms be tracked has been implemented. The recommendation from the 1 st Report that the QA Office makes this a priority in the auditing scheduling is also being implemented with the audit to be completed by 12/30/05.
Recommendation: Continue the tracking of the grievance forms. Conduct the QA audit this Fall.
Documentation: Meetings with the juvenile ombuds in each facility, meetings with Lou Goodman, Assistant Director, Legal Division and Sheila Press, Director Juvenile Ombuds Office. Meetings with youth and staff in each facility. Identification of the forms and tracking

process through the Youth Base data system. CRIPA Action Plan submitted May 20, 2005.
UFN 4.1.1.4 Ensure that grievances are examined and investigated by persons other than staff and the direct supervisors of those staff, who supervise the youth making the grievance. This provision shall not be interpreted to exclude the possible use of mediation in accordance with ADJC policy and procedure to resolve grievances.
Status: Substantial Compliance
Discussion: The revised process for the distribution of forms, filing of grievances, grievance form accountability, resolution hearings and advocacy role of the Juvenile Ombuds in each facility effectively removes the staff and direct supervisors from this process. In addition the CRIPA Action Plan is clear that all grievances involving alleged staff misconduct and/or crimes are electronically routed to I&I. All grievances sent to I&I are reviewed by supervisory personnel in I&I and either are assigned to an investigator due to the seriousness of the allegations or sent back to the Superintendent for investigation. (This has been in place since November 2004.) Monitoring will have to continue to track the effectiveness of the implementation but on paper the revisions satisfy the requirements of this UFN. The effective use of mediation, other than that employed from the youth ombuds within the current resolution meetings, has not been more fully explored to date. ADJC has had some discussion with Arizona State University regarding the development of a mediation service but that is exploratory in nature.
Recommendation: That the QA office conduct an audit of investigations involving staff misconduct to determine integrity of the process as outlined in the CRIPA action plan. Mediation enhancement continue to be explored.
Documentation: Meetings with Lou Goodman, Assistant Director, Legal Division, Sheila Press, Director Juvenile Ombuds Office and Juvenile Ombuds in each facility. Review of grievance process as outlined by diagram in policy & procedure of ADJC. Meeting with John Dempsey, Director Of the Inspections and Investigations Unit. Review of CRIPA Action Plan for UFN 4.1.1.4 in the ADJC Youthbase data system
UFN 4.1.1.5 Ensure that a youth who files a grievance is informed in writing of the results of the grievance process.
Status: Partial Compliance
Discussion: The grievance process as developed provides for the youth to attend a resolution conference within five days. The youth and the juvenile ombuds as well as the ADJC representative all sign the form indicating both presence at the meeting and agreement with the resolution or an interest in appealing by failure to sign the form. During this reporting period, however, three significant issues have surfaced. (1) At CMS during our May site visit we found that a grievance was “resolved” by sending the youth back to the cottage to meet with the supervisor and the security officer who had been the subject of the grievance. We found that this did not constitute a resolution since the youth was reluctant to meet in those circumstances with

the person who was the object of the grievance and therefore had declined to do so. In addition, what would the result of such a meeting be? (2) Currently Sheila Press reviews all IR's to confirm that resolutions have been established and implemented. (3) ADJC does not track changes to policy and procedure changes from grievances. It would seem that administrative efficiency would require that these grievances, their resolutions and resulting P&P changes be documented in order to determine that behavior that leads to grievances is not being repeated regardless of the efficiency of the actual grievance process. ADJC has complied with the recommendation from the previous report that youth are notified in a timely manner of the resolution of the grievance and that the juvenile ombuds participate and sign a form indicating participation in the resolution process. The CRIPA Action Plan, effective May 20, 2005 delineates the changes. During the July site visit a decision was made to have Sheila Press read each grievance as well as each resolution in order to determine if the resolutions are appropriate or in need of modification. This effort will be monitored in the next reporting period.

Recommendation: The Consultants Committee strongly recommends that steps be taken to audit resolutions in order to identify those that may be inappropriate similar to the one identified at the CMS site visit. That ADJC develop a process that tracks resolution implementation and that ADJC track impact of resolutions on policy and procedure.

Documentation: CRIPA Action Plan for UFN 4.1.1.5. Interview with youth during site visits in May at CMS and July at AMS and BCS.

4.2 Protection from Harm

This section is divided into two. 4.2.1 The reporting and investigation of allegations of abuse and 4.2.1 A Protection from Harm.

UFN 4.2.1 The reporting and investigation of allegations of abuse. The DOJ acknowledges that the State has made significant efforts to improve the policies, procedures, and practices for the reporting and investigation of allegations of abuse of a youth made by any person, including youth. Effective immediately upon the effective date of this Agreement, the State shall continue to make all reasonable efforts to ensure that all youth are protected from harm and that all allegations of abuse, including but not limited to physical and sexual abuse, are investigated in a timely and thorough manner by ADJC's Investigations and Inspections Unit, or other appropriately trained investigative personnel, as designated by the ADJC Director.

Status: Substantial Compliance

Discussion: Reporting and investigations of allegations of abuse:

Inspections and Investigations Unit

- (1) In the 1st Semi-Annual Report a summary of the I&I Unit was presented to demonstrate responses to allegations of abuse. The following summary is provided by John Dempsey, Administrator of I&I to update the activity documented from the 1st Report.

First Quarter:

A total of 796 incident reports were reviewed by the Investigations Division the first quarter of 2005.

39 were submitted to the County Attorney

10 were cleared by arrest

19 were unfounded

20 were cleared exceptional

41 were assigned to the Professional Standards Unit for an Administrative Investigation

14 were sustained

7 were unfounded

7 were not sustained

1 was sent to the Criminal Investigations Unit.

36 Inspections were conducted at the ADJC secure facilities

45 Service Dog (K9) searches were conducted. (7 "hits" indicating the presence of drugs occurred during this time period.)

229 background/integrity checks were conducted.

Second Quarter:

962 incident reports were received by the Investigations Division

109 were assigned to a criminal investigator

39 were submitted to the county attorney

6 were cleared by arrest

4 were unfounded

23 were cleared exceptional

54 were assigned to the Professional Standards Unit for an Administrative Investigation

12 were sustained

8 were unfounded

9 were not sustained

1 was sent to the criminal investigations unit

1 partially sustained

1 exonerated

Procedure No.1160.05, Inspections and Investigations Child Abuse Investigation. Reference: Policy No. 1160 was reviewed with the I&I unit. The main points of that policy are contained in the first section of the policy: The ADJC Criminal and Investigations Unit of the Inspections and Investigations Division (IID) shall be concerned with more than just statutory requirements and case law, during an investigation. The ADJC Criminal Investigations shall: Be cognizant of the needs of the victim; Be cognizant of the responsibilities of other organizations involved in the treatment, support and recovery of the victim; coordinate efforts with Child Protective Services (CPS) when needed; Coordinate efforts with the prosecuting agency, during an investigation. And the investigations supervisor is responsible for determining whether or not a criminal investigative response will be initiated. The policy goes on to outline training needed for the criminal special investigators, procedures for sexual abuse child abuse investigations outside of

departmental jurisdiction, sexual abuse investigations within ADJC jurisdiction, procedures for arrest, case presentation, case file development, requirements for filing with the county attorney or grand jury, crime scene investigation procedures. The policy requires that the ADJC Criminal Special Investigator notify the on call Deputy County Attorney for physical abuse cases and all cases where a youth is admitted to a hospital or dies as a result of suspected child abuse. If the ADJC investigator continues a child abuse investigation he must receive the following or equivalent training: Child physical abuse investigations and medical aspects; the investigation of sexual crimes against children; Forensic interviewing, the basic 8 hour course. Also, ADJC Criminal Special Investigator tasked with conducting an interview of a child for the purpose of obtaining evidence/statements for use in judicial hearings/trial, should have the following training; A 40 hour training in advanced forensic interview; The Children's Justice Task Force Advanced Forensic Interview training. In the Semi-Annual 1st Report part of the recommendation was that ADJC should integrate the early warning system into the I&I, QA procedures as quickly as possible. The Early Warning System is in development as part of the Employee Information Sharing System (EISS). The EISS has three major uses: One stop employee information data base for supervisors; Provides an Early Warning component that better manages employee behavior; Allows management to identify agency trends and issues. It is emphasized that the EISS is an information tool to assist supervisors with managing their employees; it is not used as a disciplinary tool but used to help employees be more successful. Supervisors in the system help identify possible problematic behaviors and or incidents that contribute to such behaviors. The second portion of the recommendation was that the Quality Assurance Unit be integrated into the I&I procedures. That has been accomplished. The First audit conducted by the QA, I&I was at CMS in May 2205. That audit will be further reviewed under the QA section of this report.

Recommendation: The Consultants Committee strongly recommends that the integration of the QA into the I&I continue as scheduled and that the audits being conducted be thoroughly documented and shared with the consultants for identification of areas of concern and improvement. The EISS needs to be implemented during the next period, as does the implementation of Policy and Procedure No. 1160 and 1160.05

Documentation: Participation in joint audit conducted at Catalina Mountain School May 23-25, 2005. Memo from John Dempsey, Administrator I&I to Michael Branham, Director, ADJC, June 21, 2005. I&I Division May Report 2005. Policy & Procedure No. 1160 & 1160.05. Outline of Employee Information Sharing System (EISS). Interviews with Megan McGlynn, Director, Quality Assurance Office and John Dempsey, Administrator, Inspections and Investigations Unit.

4.2.1 A Protection from Harm

Status: Partial Compliance

Discussion: In the 1st Semi-Annual Report it was noted that in interviewing youth many indicated that they did not feel safe within the facilities of ADJC. A review of the youth base data system provides this summary: From March 04 through April 05 the following security categories are summarized: These are monthly averages over that time frame: The rate represents "occurrences per 100 youth days."

Total # calls responded to by security: 1,020 Rate of 5.36
 Total # of separation referrals: 537 Rate of 2.83
 Total # of self-referrals to separation: 154 Rate of 0.81
 Total # Danger to self referrals to separation: 59 Rate of 0.31
 Total # Danger to Others referrals to separation: 160 Rate of 0.84
 Total # of youth injured (all sources): 239 Rate of 1.25
 Total # of youth injured in assaults by youth: 26 Rate of 0.03
 Total # of staff assaulted by youth: 27 Rate of 0.14
 Total # of staff assaulted by youth resulting in injury: 5 Rate of 0.03
 Total # of uses of force: 79 Rate of 0.60
 Total mechanical/chemical restraint usage 79 Rate of 0.42 (No usage of chemical agents, no use of a restraint chair.)
 Total # of Significant Incident Reports: 9 Rate of 0.05 (Major disturbance: 0, all assaults resulting in injuries that require off-site treatment: 47, property damage in excess of \$1,000: 0. Medical emergencies requiring off-site treatment: 0 Rate of 0.00)

This rate will continue to be calculated and observed by the consultants during the coming reporting periods.

Cottage Management Issues: Youth reported that to some extent they felt their safety was dependent upon the staff on duty. It was recommended that cottage management issues needed to be emphasized and training reviewed for content and applicability. In response to this ADJC has provided the Administrative Incident Reporting System (A.I.R.). The purpose of this report is to better manage the documentation of alleged staff misconduct, to enhance the timeliness of investigations, to ensure the consistency of discipline, to aide management in identifying training deficiencies and /or trends in conduct and to increase public confidence in ADJC personnel. This system is to operate in conjunction with the Employee Information Sharing System (EISS).

In meetings with Vickie White, the acting director of the ADJC training academy she outlined that behavior management training in the form of Therapeutic Crisis Intervention (TCI) has been instituted in the academy. 15 new instructors have been trained agency-wide. 97% of direct care staff, 23% of medical staff and 88% of education staff have been trained in all of the ADJC facilities covered in this agreement. This is a total compliance rate of 90%. To date there are 10 staff at BCS, 21 at CMS and 21 at AMS who have not received TCI training. TCI is taught to everyone, not just direct care staff. Maintenance, security, kitchen personnel etc. In addition Vickie indicated that she would be developing training to respond to the issues of cottage management, specifically the various forms of exclusion. **This curriculum is to be reviewed by all of the consultants during the next reporting period.**

Recommendation: The Consultants Committee recommends that all consultants undertake a formal review of the training content with special attention to TCI, Suicide Prevention and cottage management. In addition the EISS program needs to be implemented. Monitoring of A.I.R. and EISS can commence during the next period.

Documentation: Review of Administrative Incident Reporting System (A.I.R.) and Employee

Information Sharing System (EISS). Meeting with Vickie White, Acting Director of the ADJC training academy. Memo from Jim Hillyard of 8/9/2005 with rate calculation explanation.
UFN 4.2.2 Each youth entering the facility shall be given an orientation that shall include simple directions for reporting abuse and assuring youth of their right to be protected from retaliation for reporting allegations of abuse.
Status: Partial Compliance
Discussion: During the joint Quality Assurance, Inspections and Investigations Audit conducted at Catalina Mountain School on May 23,24,25, 2005 youth were interviewed and asked about their orientation and their understanding of how to report abuse. Those interviews were conducted by Al Carpenter of the I&I unit with Russ Van Vleet, consultant and Grady Daniels of ADJC assisting. The response to these interviews was not qualitatively different than that received during the first reporting period. Youth gave mixed reactions both to the orientation and to their understanding of abuse reporting. There is still no clear consistent application of the process that is supposed to be in place. Some youth remember an orientation at the RAC. Others do not. No youth gave examples of directions on the reporting of abuse. During this reporting period ADJC has worked on the handbook that was part of the last report's recommendation. It is to be an integral part of the orientation process. The handbook was sent to me for review during its final draft. The completed handbook was received via e-mail in my office on 7-4-05. The handbook was completed and distributed to youth during the site July site visit. The CRIPA action plan indicates that a juvenile ombuds will meet with each youth and discuss the procedures for reporting abuse.
Recommendation: The Consultants Committee strongly recommends that the handbook be implemented into the orientation process immediately. This can then be reviewed during the 3 rd reporting period for anticipated increases in understanding of the reporting of abuse and youths right to protection from retaliation. It is also recommended that a process be developed to document the meetings of the juvenile ombuds with each youth for orientation to reporting abuse.
Documentation: Participation in the First Technical Assistance Visit conducted at the Catalina Mountain School, May 23-25, 2005. Review of handbook draft. CRIPA Action Plan dated 4/25/05.
UFN 4.2.3 In collaboration with the local office of Child Protective Services and with local law enforcement, the facilities shall develop and implement policies and procedures regarding steps that must be taken immediately upon the reporting of an allegation of abuse in order to preserve evidence and to protect youths pending an investigation of the abuse.
Status: Partial Compliance
Discussion: ADJC has developed Policy and Procedure No. 1160 and 1160.04-5. This P&P contains the requirement that ADJC coordinate efforts with Child Protective Services (CPS) "when needed". Also, to establish and maintain a close working relationship with CPS, to cross

report to CPS, to review prior CPS reports when conducting investigations, that their case presentations contain CPS files on the youth and the family. The ADJC criminal special investigator's case file shall contain all information from the CPS investigation. P&P 1160 and 1160.05 contain the requirement that CPS be notified in cases of reported abuses. These Policies and Procedures contain the necessary steps that must be taken for the reporting of abuse and to protect youths pending an investigation of the abuse.

The settlement agreement contains language that requires the notification and involvement of the local CPS office in ADJC child abuse investigations. The development of the Investigations and Inspections Unit (I&I) however may preclude this requirement. John Dempsey, I&I administrator explains that his investigators are Arizona certified police officers and their investigation of the allegations of abuse satisfy the requirement of an "outside" investigation. In fact, the referral of the allegation to CPS only results in a return of the referral to ADJC since their investigators have the same qualifications as those at CPS. In addition, the workload on CPS precludes that agency's involvement in ADJC investigations and referrals to that agency are not met with timely responses. The issue facing the monitoring aspects of this UFN is to what extent an investigation by the I&I unit, administratively connected to ADJC, provides the necessary arms length review of conditions within the agency and therefore qualifies as an "outside" investigation.

On July 26, 2005 I&I Administrator Dempsey, Deputy Director Gadow, QA Administrator McGlynn met with Janice Mickesn, CPS Program Administrator and Program Manager Carla Conradt to discuss ADJC reporting requirements to CPS. Also present was an attorney from the AG's Office. ADJC was advised of the following: (See full text of memo in Appendix A.)

- 1- CPS adheres to a strict interpretation of ARS 13-3620 as it pertains to required reporting of child abuse crimes-that is that the statute is satisfied by these allegations that occur within ADJC jurisdiction when they are reported to Inspection and Investigations-of which AZPOST police officers are members thereof.
- 2- Staff members alleged to have committed crimes contained within this statute against a youth adjudicated to ADJC will not be reported to the CPS Hot-line.

This is an area in which counsel from the DOJ and ADJC may need to review the language of the settlement agreement for possible revision

A review of the agreement between ADJC and CPS and its acceptance by all parties is what would be needed for substantial compliance of this UFN.

Recommendation: It is recommended that during the next reporting period the implementation of these new policies and procedures be tracked. In addition, that the question of the need for and propriety of CPS involvement in ADJC child abuse investigations be reviewed by both parties and necessary amendments made to the settlement and/or the policy and procedure in order for substantial compliance to be achieved. It is recommended that the Consultant's Committee meet with Director Branham, Administrator Dempsey and Lou Goodman for a complete review of the status of ADJC's agreements with CPS.

Documentation: Review of Policies and Procedures numbers 1160/. 05. Interviews with Megan McGlynn, QA Director and John Dempsey, Administrator of I&I.

<p>UFN 4.2.4 Each youth who reports to the Health Unit with an injury shall be questioned by a nurse or other health care provider outside the hearing of other staff or youths, regarding the cause of the injury. If, in the course of the youth's infirmity visit, a health care provider suspects abuse, that health care provider shall immediately:</p>
<p>Status: Partial Compliance</p>
<p>Discussion: The action plan dated 4/25/05 indicates that medical staff have been informed of the need to insure privacy and to focus on maintaining a confidential interview setting. A new health unit is being built at Adobe. As part of the QA process a youth healthcare report card is issued and it will be revised to include a question about whether or not the youth was questioned about his injuries in a private setting. Each month the names of ten youth from each institution are sent to a juvenile ombuds to administer the healthcare report card surveys to selected youth.</p> <p>The wall that was referenced in the health unit at CMS in the 1st report has not been modified. The agency is in the process of taking bids for the construction.</p>
<p>Recommendation: Monitor the healthcare report card through the QA process. Document the physical plant revisions that improve the delivery of health care.</p>
<p>Documentation: CRIPA Action Plan. CMS QA site visit</p>
<p>UFN 4.2.4.1 Take all appropriate steps to preserve evidence of the injury (e.g. photograph the injury and any other physical evidence);</p>
<p>Status: Substantial Compliance</p>
<p>Discussion: The CRIPA Action Plan indicates that victims of sexual assaults are examined by a Sexual Assault Nurse Examiner (SANE) staff or sent out to an emergency room to ensure forensic evidence is preserved and documented. The procedure was outlined in the discussion portion of the 1st report. The monitoring of this will coincide with the QA practice of pulling incident reports of youth who have sustained injuries to determine that youth were interviewed by nurses with specialized training (SANE). In addition, the captains of security at AMS and BCS were interviewed along with John Dempsey administrator of I&I and procedures for the security of evidence reviewed. That practice is reviewed in the 1st report (in this UFN) and continues to be an effective and efficient method for preservation and protection of evidence. In the 1st report a question was raised as to the appropriate oversight of the captains of security. John Dempsey, I&I Administrator, addressed this in the July site visit and detailed how I&I provides the oversight for the gathering and preservation of evidence. This is somewhat confusing only in that the CRIPA action plan dated 4/25/05 indicates that the responsibility for this lies with Dr. Kellie Warren. The connection between the health care personnel and the captains of security and the responsibility of each will have to be more carefully examined in the next reporting period.</p>
<p>Recommendation: The Committee recommends that youth that receive review by a SANE staff be tracked and the process monitored for compliance during the next reporting period.</p>

Documentation: CRIPA Action Plan. Meetings with Captains of Security at AMS, BCS and John Dempsey, I&I Administrator.
UFN 4.2.4.2 report the suspected abuse to the investigations and Inspections Unit, which shall in turn report it to the local Child Protective Services office;
Status: Partial Compliance
<p>Discussion: The CRIPA Action Plan calls for nursing staff to make a direct phone call to I&I and to immediately document suspected abuse in the youth's medical record. The plan also includes updating the procedure to reflect current practice and for I&I to develop a tracking mechanism. (See discussion in the 1st report and discussion in 4.2.3 above).</p> <p>In the first report there was an indication that CPS would be contacted by the Consultant's Committee for a discussion of its responsibility for ADJC referrals. That did not occur due to the updated information from Administrator Dempsey.</p> <p>Also, in the 1st report a clarification of the health care provider's role in the investigative process was requested. Further discussion was held regarding that issue without a firm resolution. While the health care provider's role was confirmed to be valuable the confidential nature of the investigation may preclude any possibility of enhancing that role or apprising them of the results of investigations as had been requested during the first reporting period by health care professionals interviewed. A more thorough discussion of this will have to continue during the next reporting period.</p>
Recommendation: The Consultants Committee recommends that the role of CPS be clarified during the next reporting period. (See UFN 4.2.3) In addition, members of the health care teams along with Dr. Kraus and Dr. Warren should review this UFN for further clarification/modification of the health care provider's role that they may see as appropriate. Follow the Action Plan Summary.
Documentation: CRIPA Action Plan. Discussion with John Dempsey, I&I Administrator, Captains of security.
UFN 4.2.4.3 document adequately the matter in the youth's medical record; and
Status: Partial Compliance
<p>Discussion: In discussions with Dr. Louis Kraus and John Dempsey, administrator of I&I the documentation in the medical record appears to be adequate. The CRIPA action plan calls for a review of investigations through I&I with documentation of incidents in the medical record. This process, through QA is just beginning and will require time for monitoring in order to achieve substantial compliance. The 1st report recommended that a notation by the nursing staff of receipt of an incident report would connect incidents with IR's. Monitoring will determine that.</p>
Recommendation: Determine if a notation in the medical record of the receipt of the IR is

necessary and helpful to the monitoring of abuse.
Documentation: CRIPA Action Plan. Discussion with Dr. Kraus, QA audit team and John Dempsey, Administrator, I&I.
UFN 4.2.4.4 complete an incident report.
Status: Substantial Compliance
Discussion: The incident reporting process has been modified with resolution meetings being held that include the juvenile ombuds. These meetings are memorialized through a form that includes the resolution and signatures of all parties indicating acceptance of the resolution or the need for an appeal.
Recommendation: Continue tracking of IR's for compliance.
Documentation: Review of the new forms requiring resolution agreement and attendance by the juvenile ombuds. Interviews with the juvenile ombuds in the three facilities to verify their attendance and agreement with the new policy and procedure. CRIPA Action Plan.
UFN 4.2.5 Within six months of the effective date of this Agreement, the State shall develop and implement policies directing how, when, and to whom (including to Child Protective Services, law enforcement officials, and/or facility administrators) allegations of abuse shall be referred and investigated. A referral to Child Protective Services shall be made in accordance with Arizona state law, and an abuse investigation shall be warranted, whenever;
Status: Partial Compliance
Discussion: The Procedure No. 1160.05, Ref. Policy No. 1160 in the manual of Policies & Procedures was referenced in the 1 st Semi-Annual Report and in previous sections of this report. Although it was issued in May of 04 it is still listed as draft in the version that I have reviewed. This P&P covers requirements for reporting abuse of youth in all areas of ADJC jurisdiction including employees, volunteers, interns, service providers under contract to ADJC, secure facilities, and safe schools and in the community. All child abuse reports, from all facilities are reported to CPS. Proper procedures for conducting the investigations are contained in these P&P's. In addition Policy & Procedure No. 1160 written 4-27-05, currently in draft form also adds to the instructions for handling allegations of abuse to youth. Since the 1 st report the Employee Information Sharing System (EISS) has been installed and the Administrative Incident Reporting System (A.I.R.) introduced and soon to be installed and they are beginning to provide information to administration for responding to allegations of abuse. This remains in partial compliance because the Consultant's Committee still needs to meet with CPS for confirmation of its role in this process.
Recommendation: The tracking system needs to be reviewed to better understand how a determination is made to investigate, who conducts it (person within ADJC) and CPS role, if any, in the investigation.

Documentation: Policy and Procedure Numbers 1160, 1160.05 and 0000.00. Meetings with Megan McGlynn, Director of QA and John Dempsey, I&I Administrator. Review of A.I.R. and EISS systems.
UFN 4.2.5.1 a health care provider, staff or youth reports suspected abuse; or
Status: Partial compliance
Discussion: The development of Policy and Procedure discussed in the preceding UFN's responds to this issue. One issue, identified in the 1 st Report was the appropriate involvement of health care personnel. In the abuse referral process a tracking system, as recommended in the 1 st report has been developed. That report was reviewed. It includes the youth name, K#, status, Investigation ID, IR ID, the incident date, the allegation, the investigator and the conclusion date. This pending case log, which contains approximately 3 months of entries, allows the reviewer to know the status of each case. Regarding the health care provider involvement, this report could be made available to appropriate personnel in the medical units. The issue is the maintenance of confidentiality. This form does not divulge personal information only the status of the investigation. If someone from the health units had concerns about the status of an investigation they would be able to ascertain the investigator involved in the case and the status of the investigation. This issue needs further discussion in the next reporting period.
Recommendation: The Consultants Committee recommends that the tracking system be made available to identified medical personnel in each facility.
Documentation: Review of Policy and Procedure Numbers 1160, 1160.05. Discussion with Dr. Louis Kraus, health care providers within the facilities. Interviews with Megan McGlynn, QA Director and John Dempsey, I&I Administrator.
UFN 4.2.5.2 an incident report, use of force report, injury report, grievance or other source of information provides a credible basis for concluding that abuse may have occurred.
Status: Partial Compliance
Discussion: The recommendation from the 1 st Report was the adoption of the best practice for reporting abuse. During the 1 st reporting period the process was different at each facility. It is not clear at this time that a best practice has been agreed upon.
Recommendation: The Consultants Committee strongly recommends that best practice be determined and then replicated in each facility.
UFN 4.2.6 Effective six months from the effective date of this Agreement, the facilities shall provide appropriate behavior management/crisis intervention training to staff before staff may work in direct contact with youths.

Status: Partial Compliance

Discussion: In the Action Plan submitted by Vickie White, Interim Staff Development Administrator, dated May 20, 2005 it indicates that ADJC offers a 24-hour Therapeutic Crisis Intervention (TCI) course in the Pre-Service Training Academy, which instructs staff in appropriate behavior management/crisis interventions when dealing with youth. The curriculum is based on performance objectives (course competencies). TCI is offered to all direct contact staff. This training began in March 2005. TCI is a mandatory class for all personnel (new and existing) working behind the fence and in the community. This includes education, medical, maintenance and food service personnel. The only exception is administrative support positions that do not have contact with youth. The CRIPA compliance report shows that training for suicide related issues is from 75% to 92% completed for all ADJC facilities. Training for TCI is at 90% for Direct care, medical and education staff at the AMS, BCS, and CMS (See UFN 4.2.1A).

The current courses in pre-service academy pertaining to CRIPA Review include:

- Adolescence
- CAPFA Review
- Cognitive Behavioral Approaches
- Contraband Searches & Seizures
- Handle with Care
- Housing Unit Operations
- Managing Mental Health Youth
- Medication Administration
- Observation & Documentation
- Suicide Prevention 2005
- Therapeutic Crisis Intervention
- Thinking for a Change Strategies
- Use of Force

The 1st report asked for a content evaluation. The training curriculum, including an outline of the courses, has been forwarded to all of the consultants for their review. That review will be included in the next report.

Recommendation: The Consultants Committee recommends that QA include in its newly developed procedures, content-based evaluations of the training. Competency scores are important but only reflect the learning of presented material. The relevance of that material must also be validated.

Documentation: Discussion with Vickie White, Acting training director. The All Facilities CRIPA Compliance Report through July 29, 2005. Course listing from the Pre-service Academy and current ADJC pre-service training courses, July 2005.

UFN 4.2.7 All staff shall continue to complete successfully competency based training in behavior management/crisis intervention before working directly with youths.

Status: Partial Compliance
<p>Discussion: The academy has been changed to have TCI included in new employee orientation. The Academy orientation requires that employees pass tests. If employees do not pass tests they are not employed. A concern has been raised concerning senior employees who have not attended academies and not been required to complete competency training. Since annual training does not require competency testing we need to know if they are competent. During the next reporting period all employee lists will be reviewed in order to identify anyone identified as direct care staff, not academy trained and therefore not competency verified. If we identify anyone a decision would have to be made about requirements for competency to continue working as a direct care staff.</p> <p>Overall Competency rates for this period are 92% for suicide prevention (less in some related suicide prevention training courses) and 55% for TCI.</p> <p>The same recommendation from the 1st Report is repeated in this report.</p>
<p>Recommendation: The Consultants Committee would recommend that ADJC look at training requirements that ensure that all direct care staff complete training before working in direct care positions. Suicide prevention training almost qualifies all of the staff but Therapeutic Crisis Intervention training is completed by less than 3 out of 4 staff. With the number of youth in facilities TCI training would seem to be mandatory prior to working. In addition, a policy that does not allow those who fail competency tests to work with youth should be implemented. Content evaluations should also be part of this policy to ensure relevance to work environment.</p>
<p>Documentation: Meeting with Acting Academy Director Vickie White. Review of All Facilities CRIPA Compliance Report Through July 29, 2005.</p>
<p>UFN 4.2.8 The State shall evaluate regularly the training and the trained techniques through quality assurance data (including data correlating use of force incidents and abuse allegations with data measuring the efficacy, occurrence of, and staff participation in training programs), Performance based standards data, evaluations from training program participants, Incident Review Team reviews of use of force incidents, abuse investigation reports, interviews with staff and youths, and other means evidencing the efficacy of the trained techniques in managing behaviors and crisis interventions at the facilities. As warranted, the facilities shall adjust the training curriculum based on such evaluations.</p>
Status: Partial Compliance
<p>Discussion: A curriculum committee has been developed and some evaluations have taken place. The committee activity was not available for review during this reporting period. Evaluations of training have not been made available to the consultants at this time. The QA site visits have just begun and the next reporting period will allow the consultants to examine the results of those visits and the information needed for a more thorough review of this UFN.</p> <p>The recommendation from the 1st report is repeated here. This training through the academy is</p>

on-going but the evaluation of the training will require more time.

Recommendation: ADJC needs to develop post-tests that determine competency of staff post training. Staff should be required to successfully pass competency testing before beginning or resuming direct care duties. ADJC needs to develop a survey or questionnaire that will address content evaluation. Training of trainers is important but delivery and retention need to be addressed for each of the academies.

4.3 Staffing

UFN 4.3.1 The DOJ acknowledges that the State has embarked on a plan to add necessary additional direct care staff positions. The State shall ensure that there are sufficient numbers of adequately trained direct care and supervisory staff to safely supervise youth and protect youth from harm.

Status: Partial Compliance

Discussion:

In the 1st report it was pointed out that in order to provide adequate supervision and to subsequently have an expectation of few incident reports, and no incidents that result in injuries to youth or staff, cottages should not exceed 25 youth. Due to increases in population (which is not within the control of the ADJC) Arizona now operates six cottages at a capacity of 32 youth. Five cottages at Adobe Mountain School and one Cottage at Black Canyon School. On August 7, 2005, the Kachina cottage had 37 youth listed as residents although (5 were out of the facility). Freedom had 34 residents (3 out of the facility) and Recovery had 33 residents (2 out of the facility). (Youth not in the facility were temporarily elsewhere during the time of the site visit.)

A total population of 301 residents at AMS.

The current direct care staffing at ADJC shows:

2-3-2 staffing for a 24 youth unit. This would be ratios of 1:12, 1:8, and 1:12.

3-4-2 staffing for a 32 youth unit. This would be ratios of approximately 1:11, 1:8, and 1:16.

In addition there are 4 treatment staff assigned to a 24 bed unit and 5 to a 32 bed unit.

ADJC does comply with ratios during the day time shifts since youth are in school during the morning hours, except on weekends (direct care staff accompany youth to school and either act as aides in the class room or as security) and midnight shifts as long as the cottage population does not exceed 32. Once that population exceeds 32 ADJC is out of compliance. The only thing allowing compliance with the afternoon shifts in several AMS cottages is the number of youth who have been transferred to jail pending disposition in the adult court.

Of substantial concern at this time is that ADJC is meeting ratios using a great deal of overtime. Policy has been developed and overtime is being monitored. The policy states that no one may

work more than 24 hours of overtime per week unless approved by the superintendent.

Superintendents are going to continue to make judgment calls about the effectiveness of staff and safety of youth and staff when authorizing overtime work. If cottage populations continue to increase and turnover rates continue as they currently are (see below) meeting ratios may not only not be possible but in some cases not desirable due to the hours some staff may be working, and the resultant concerns about that amount of work in a corrections environment.

ADJC is aware of the increases in population and has funded positions. The problem is the recruitment and retention of quality staff. Recruitment efforts have been increased for the next several months. Traditional recruitment venues include newspaper advertisements, job fairs in the Phoenix and Tucson metroplexes, internet postings and partnerships with DES offices. In addition, ADJC is attending a job fair in the Los Angeles area in September, 2005. (Los Angeles was chosen because on ADJC's internet job posting the highest number of out of state candidates were from Southern California.) Academies are planned for September 26th, October 17th and November 14th. All of these cadets will graduate prior to January 1, 2006. The academy class that started on September 6th had 22 cadets.

Salaries are not competitive with some other governmental entities. In Maricopa County where ADJC has 3 institutions, the county juvenile detention officers' starting salary is \$31,180 compared to ADJC's officers starting at \$26,608. This is an obvious disadvantage when recruiting new staff. The demands of the work environment requires competitive salaries. If salaries are not made competitive staffing ratios will not be met, programming effectiveness greatly diminished and incidents, including serious ones likely to increase. In order to recruit and retain quality staff salary increases need to be provided as service and competency increases. ADJC requested \$4,500 for salary increases in FY 2006 with only \$1,410 approved and funded.

During the 1st reporting period there were no cottages reporting more than 28 youth in any one cottage.

During this reporting period, due to increases in population there are now 6 cottages with more than 28 youth.

ADJC is confronted with an increasing population in its facilities and this increase will challenge the system's ability to attain compliance with this provision. The following population counts were provided at the July site visit:

Adobe 313

Black Canyon 96

Catalina Mountain 116

Eagle Point 141

Total: 666

Population projections for purpose of staff allocations was set at 624.

The FY 2005 and FY 2006 staffing:

Direct line staff:

FY 2005: 32 additional positions (YCOs 1,2,&3's)

FY 2006: 49 additional positions (YCO's, 1,2,&3's)

Treatment staff:

FY 2006: 27 additional positions; (YPO 3's)

This is 108 additional positions which is 19% of FY 2004 Base budget

ADJC Current Facility Vacancies (As of mid-July 2005)

YCO 1 & 2's: 463 funded, 100 vacant for a 21.6% vacancy rate

YCO 3's and Sgts: 45 funded, 28 vacant for a 62.2% vacancy rate

YPO 3's: 91 funded, 28 vacant for a 30.8% vacancy rate

PA 2's: 31 funded, 8 vacant for a 25.8% vacancy rate

YPS: 39 funded, 3 vacant for a 7.7% vacancy rate

Recruitment and promotions create a dynamic environment for counting vacancies at any point in time. By the first of August 2005, the above 28 vacancies for YCO 3's were filled. However, all of the candidates were internal which increased the YCO 1&2 vacancies by 28. Interviews are scheduled for the first week of September 2005 for the YPO 3 and YPS vacancies. Most of these vacancies will be filled by internal promotions. While it is important to fill vacancies at all levels, internal promotions just shift the vacancies to another job classification. In order to have an impact on overall vacancies, new recruits must be coming in the door. Again to attract new recruits and retain quality staff, salaries must be competitive with similar government entities in the state.

During the May 23-26 Technical Assistance Visit by the Quality Assurance Unit of ADJC the following was reported:

- (1) Housing Units were able to produce staff reports for the month of May. On many of the reports, there was an offer of overtime but shifts were still not filled.
- (2) There is a significant amount of overtime being offered and utilized at CMS. Many staff are working extra shifts. The number of open positions prevents them from having full staffing on the units without the use of overtime.
- (3) Weekly staff accountability reports are current. Most of them had overtime shifts to meet minimum coverage needs.
- (4) **Documentation of procedure 4002.05, requiring notification to Assistant Director of Secure Schools when working under ratio not present.**

During the site visit monitors from the QA team visited each cottage to document coverage. The results were: On 5/23, 2005 ratios were met in all cottages during random walkthroughs at all shift times with the exception of Manzanita at 1725 hours when there were 2 staff and 21 youth. There must be 3 staff for 21 youth. On 5-25-05 Mesquite and Recovery cottages were audited with staffing ratios being met.

In addition, the report offers this observation: "An issue of staff coverage was apparent when a youth was put on one-on-one status. The QMHP put this youth on this status, she requested that he remain on his unit and not go to separation. At the time, there was not enough staff to

implement the one-on-one with youth and meet minimum ratios. It took a few minutes before a staff was located (from separation) for coverage. It appeared that coverage was an issue and it wasn't clear that the youth would be able to stay on his unit with one-on-one as the QMHP requested. If separation had more youth referred, there would not have been enough coverage there either. Staff are cooperative and try to assist in shortage situations, but it appears that there is constant shuffling of staff to meet minimum ratios. Even with the overtime offers, there seemed to be a lot of exceptions for coverage, such as recreation staff covering units, separation staff covering for a one-on-one unit, etc. This type of thing happened every day the auditors were present." (QA Audit, CMS, May 23-26, 2005).

The QA audit also reported the following: As of October 2004, there were 7 (combined) YPO I and YCO II positions open and 1 Psychology Associate position open. At the time of the audit, there were 17 YPOI and YCO II positions open and four Psychology associate positions open. These open positions would significantly impact line staff coverage. In an interview with staff the audit also reports that there is always overtime available and staff feel as though there is not enough staff for coverage. They report feeling overwhelmed and tired of simply trying to meet minimum standards. Staff expressed a concern about how coverage is met when someone calls in sick, the facility has to shuffle staff from housing unit to housing unit and often results in staff that are unfamiliar with the youth or routine in that unit.

An audit of AMS was being conducted during the July site visit and the results of the staffing review from that audit will be included in the 3rd semi-annual report.

I had the opportunity to participate in the CMS audit. It was a very thorough and professional exercise with full cooperation and participation of the CMS administration and staff. One observation that illustrates the staffing issue: A member of the CMS recreation staff greeted us at 8 a.m. the first day of the audit. He was still there when we returned for a late night visit, having picked up an additional shift and overtime pay. The next morning, he was once again on duty and indicated that he would be there again for a double shift. This type of staffing provides additional dollars for some staff but causes some very obvious concerns. One is the staff person providing the coverage is not a direct care staff and had not received the training that direct care staff need in order to adequately provide coverage. Secondly, someone working that number of hours, even if a recipient of the training is not able to perform at a level necessary to ensure the safety of staff and residents. Cottage security is compromised with this type of overtime coverage and as the audit points out this is routine at CMS at the present time.

Lastly: The tendency in many corrections systems is to simply continue to add cottages to training school campuses as populations increase. Even if cottage populations are maintained at 32 or fewer the sheer number of youth housed in one complex begins to make the facility unmanageable. Juvenile Justice professionals have recognized as best practice that training schools should be limited in total number of residents. (ACA suggests no more than 100 youth be housed in any one setting). The ADJC surpassed that best practice many years ago. It is important that the increase in population be recognized and confronted now. The Arizona juvenile justice system must examine changes in both commitment and release practices if the ADJC facilities are to be kept at a reasonably acceptable safe number of residents.

<p>The recommendation from the 1st report is repeated since verification of changes from those recommendations were not found during this reporting period. Additional recommendations are also offered.</p>
<p>Recommendation: The Consultants Committee recommends that ADJC adopt the “on-shift” report currently being utilized at BCS as the best method of providing assurance that staffed ratios are actually met through notification of critical posts during staff changes. In addition, Security captains at each facility on each shift should verify presence of staff at critical posts through random checks that are documented. ADJC should also document shift coverages in each facility to determine hours being worked, by whom, in order to determine maximum hours allowed in any one period. ADJC should also review staff coverage, overtime, with incidents to determine if patterns exist that would instruct changes in policy regarding coverage limits.</p>
<p>Documentation: CMS audit participation, CMS audit of May 23-26, 2005. ADJC FY 2006 FTE Allocation Summary of July 18, 2005 prepared by Debra Peterson, Assistant Director-Support Services. Memo from Debra Peterson of 8/10/2005 to Grady Daniels that included populations of all ADJC cottages, staffing requirements by cottage and the ADJC youth unit position allocation for direct line staff and treatment staff.</p>
<p>UFN 4.3.2 The State shall continue to ensure that there are adequate staff to provide adequate security for the facilities; permit youth to use the bathroom facilities in a timely manner and provide a sufficient level of supervision to allow youth reasonable access to medical and mental health services, education, and adequate time spent in out-of-room activities.</p>
<p>Status: Partial Compliance</p>
<p>Discussion: The procedure for bathroom remains the same as reported in the 1st Semi-Annual Report. Each facility maintains a log of bathroom requests and the response time for each call. These logs are reviewed to ensure an adequate quantity and timeliness of response. In addition ADJC has requested an additional third shift staff for every housing unit in its’ annual budget request. That request was funded by the Arizona legislature and ADJC is filling the positions. .</p> <p>Partial Compliance is provided due to the need for further monitoring. Reasonable access to medical and mental health services, education and adequate time spent in out-of-room activities will require continued monitoring. There is no indication at the time of this reporting that youth do not have adequate access to the bathroom facilities in a timely manner, or access to medical and mental health services or education. The issue of adequate security and out-of-room activities is intertwined with staffing patterns and will require additional monitoring to determine adequacy and compliance.</p> <p>AMS had been in the process of limiting the use of cottages that have rooms without toilets but due to the recent increase in student population that effort has been stopped.</p> <p>ADJC was funded for 3rd shift positions in FY 2006. As vacancies decrease, staffing will be available to cover the 3rd shift with 2 FTE positions per unit. The dry rooms units should be the first to implement the additional 3rd shift cover</p>

Recommendations: ADJC needs to continue its efforts to close cottages that house youth in rooms without toilets.

Documentation: CRIPA Action Plan submitted 4/20/05. Policy #4002.07. Discussion with Jim Hillyard, staff at AMS during the July site visit.

4.4 ADJC's Investigations and Inspections Unit and Quality Assurance Team

UFN 4.4.1 ADJC has created the Investigations and Inspections Unit within ADJC to consolidate and supplement quality assurance activities already undertaken by ADJC in accordance with this Agreement. ADJC has hired, from outside ADJC, an Administrator for the Investigations and Inspections Unit, who reports directly to the Director of ADJC. ADJC shall continue to provide the administrator with sufficient staff and resources to perform the tasks required by this Agreement.

Status: Substantial Compliance

Discussion: In UFN 4.2.1 a breakdown of monthly activity is provided that gives an example of the workload of this office.

In the CRIPA Action Plan, effective June 2004 a complete outline of this office is provided. It is important to point out that this office has grown from 5 to 20 personnel with two separate divisions, Investigations and Inspections. Since the 1st Semi-annual report there have been several improvements in the Division. An employee conduct policy was written in order to promote consistent discipline and identify consequences for unacceptable behavior. An administrative investigation policy was written in order to outline processes and protocols for administrative investigations. An automated case management tracking system and electronic reporting and management system developed. The working relationship between I&I and ADJC legal staff (youth rights/ombudsman) and AG liaison improved. Two K-9 officers graduated from APOST K9 academy. This program is to staunch known conduits of drugs into the facilities. Improvement of relationships with Maricopa and Pima county Attorney's Office where ADJC facilities exist. All investigators are attending classes to enhance investigative skills and knowledge. An interview room with video and audio taping capability constructed in order to memorialize for court purposes, interviews of staff and youth. An Early Warning System (identification early on of employee behavior issues that could affect the safety and security of youths-that allows for early intervention and correction) is being developed. In the 1st Report it was recommended that a determination be made as to the capability of this office to conduct investigations. The outline of activities indicates that the office is actively conducting investigations.

Recommendation: During the next reporting period connect activities of I&I with changes in personnel, P&P and incidents in order to demonstrate if I&I activity makes for a safer institutional environment.

Documentation: Meeting with John Dempsey, Administrator of I&I. Review of CRIPA Action Plan submitted April 4, 2005.
UFN 4.4.2 ADJC shall create a Quality Assurance Team, the Administrator of which shall report directly to the Director of ADJC. The Quality Assurance Team shall work in conjunction with the Investigations and Inspections Unit.
Status: Substantial Compliance
Discussion: The organization chart of ADJC for operations shows the Quality Assurance as one of 6 offices directly under the Deputy Director. The I&I Administrator reports directly to the ADJC Director. To demonstrate how these two units work together a flow chart is provided in Appendix B. The QA designs the audits, the audit is conducted with I&I and QA collecting the data, QA analyzes the data, develops the reports, implements remedial plans and then I&I conducts follow-up inspections on the recently conducted audit. In addition to audits, these two divisions of ADJC conduct inspections, PBS and investigations jointly. The first audit (technical assistance site visit) was conducted at CMS, May 23-25, 2005. The development of that report will be the first attempt to demonstrate how the two will work together.
Recommendation: Review CMS audit with QA & I&I for findings, reporting, implementation of recommendations. Conduct meeting with Consultants as recommended in 1 st Report.
Documentation: Participation in first QA, I&I audit at CMS, May 23-25, 2005. Review of Organization chart provided by QA. Meetings with QA director Megan McGlynn and I&I Administrator, John Dempsey. Joint meeting with Consultants Committee, QA and I&I.
UFN 4.4.3 The Investigations and Inspections Unit and the Quality Assurance Team, in Coordination, shall be responsible for the following tasks:
UFN 4.4.3.1 monitoring compliance with Department policies and procedures in the facilities, with emphasis on policies and procedures relating to issues addressed in this Agreement;
Status: Partial Compliance
Discussion: The CRIPA Action Plan indicates that a reporting format was developed and implemented where the Director, Deputy Director, Assistant Director of Secure care, Quality Assurance and the Appropriate facilities Superintendents collaborate with QA in developing tracking mechanisms to capture relevant data that identifies deficiencies in P&P and implements improvements in P&P. The first audit, conducted at CMS, May 23-25 will be used to demonstrate progress in the collaboration of these two divisions and the ability to utilize information from that audit for identification of deficiencies and improvements based on the audit findings.
Recommendation: In the 1 st reporting period it was recommended that a master list be developed of pending audits. That recommendation is continued so that the consultants may participate in the audits, examine the findings and monitor the implementation of

recommendations of those audits.
Documentation: CRIPA Action Plan, submission date of April 4, 2005.
UFN 4.4.3.2 conducting audits and other quality assurance activities as described in 4 (d) below;
Status: Partial Compliance
Discussion: The first audit was conducted by the QA and I&I divisions on March 23-25, 2005 at CMS. Other audits are now being scheduled. The results of that audit are now being reviewed in detail and will be included in the next report.
Recommendation: Forward results of audits conducted to consultants for identification of settlement agreement issues that can be addressed and remedied in order to gain full compliance.
Documentation: CRIPA Action Plan, submitted April 4, 2005. Participation in audit at CMS, May 23-25, 2005.
UFN 4.4.3.3 reviewing and, where appropriate, investigating allegations, of child abuse;
Status: Substantial Compliance
Discussion: The I&I Unit is actively investigating allegations of child abuse and that has been detailed in earlier portions of this report. QA has just begun its participation in these investigations and will be more thoroughly reviewed in the next reporting period. It is important to emphasize that all allegations involving alleged staff misconduct and /or child abuse crimes are electronically routed to I&I for assignment. If an investigation reveals that a felony crime did occur the case is submitted to the local County Attorney for a review of the charges.
Recommendation: Identify any cases where a felony crime did occur and track the handling of that case from I&I to the County Attorney. If no felony cases were found, review allegations of child abuse for decision-making by I&I with respect to investigation assignment and case resolution.
Documentation: CRIPA Action Plan, April, 2005 submission.
UFN 4.4.3.4 assuring the implementation and adequacy of the educational, medical, and mental health quality assurance programs required by this Agreement; and
Status: Partial Compliance
Discussion: The QA Division has just been organized and has begun to conduct audits. The CRIPA Action Plan calls for the QA Administrator to work with education, medical and mental health to develop internal QA plans. The medical and mental health policies were completed 4/30/05. The education plan was completed 5/30/05.
Recommendation: Conduct meetings with the Consultants Committee during the next reporting

period so that adequacy of QA process can be reviewed and determine if timelines have been met.
Documentation: CRIPA Action Plan submitted 4/19/05.
UFN 4.4.3.5 coordinating quality assurance activities performed by various Division offices to prevent unnecessary duplication of efforts.
Status: Partial-Compliance
Discussion: The flow chart is contained in Appendix B. Audits will continue to be conducted and then reviewed by the Consultants. The Committee of Consultants will participate in audits whenever possible. Duplication of efforts will have to be reviewed as further audits are conducted. The CRIPA Action Plan indicates that all departments will be required to submit all quality assurance activities to the QA office. The QA office will coordinate QA activities within ADJC. Expected completion date for coordinated agency plan is 12/05.
Recommendation: Same as 4.4.3.4
Documentation: CRIPA Action Plan submitted 4/19/05.
UFN 4.4.4 The Quality Assurance Team, in collaboration with the Inspections and Investigations Unit, shall create and implement a written quality assurance program, as defined in the Definitions Section of this Agreement, as supplemented below:
Status: Partial Compliance
Discussion: This UFN remains unchanged. The QA program is being developed but it has not been formally presented to the Consultant's Committee.
Recommendation: Review with the Consultants Committee the first audit for its relevance to I&I and quality assurance issues.
Documentation: No CRIPA Action Plan yet developed, no written QA plan yet submitted to Consultants.
UFN 4.4.4.1 The comprehensive audits as specified in the Definitions Section shall include:
UFN 4.4.4.1.1 inspection of institutional, medical and educational records, unit logs, incident reports, use of force reports, major disciplinary reports, documentation of room checks by line staff, etc.
Status: Partial Compliance
Discussion: The first Audit conducted at CMS on May 23-25, 2005 should contain all of the elements identified in this UFN. That completed report was released to the Consultant's

Committee late in this reporting period.
Recommendation: Determine if the audit protocols satisfy the recommendation from the 1 st Report, which was to develop a monitoring protocol that includes a review of all SIR's and a random selection of others on at least a monthly basis. The incident itself should be reviewed for accuracy of reporting by staff, and then the process reviewed for thoroughness and appropriate resolution.
Documentation: No CRIPA Action Plan yet developed.
UFN 4.4.4.1.2 Interviews with staff, administrators, and youth at each facility;
Status: Partial-Compliance
Discussion: The QA has begun its interviews with staff, administrators and youth through the first audit conducted at CMS May 23-25, 2005.
Recommendation: Work with the Consultant's Committee during the next reporting period to determine the purpose of the interviews and questions that should be included in the interviews.
Documentation: No CRIPA Action Plan. No activity to date with the Consultant's Committee.
UFN 4.4.4.1.3 where appropriate, interviews with the parents or other care givers of youth confined in the facilities;
Status: Non-Compliance
Discussion: To date interviews have not been conducted.
Recommendation: Work with the Consultant's Committee so that some interviews can be conducted jointly during site visits.
Documentation: No CRIPA Action Plan submitted. No documentation available to the Consultants regarding activity related to this UFN.
UFN 4.4.4.1.4 inspection of the physical plant;
Status: Partial Compliance
Discussion: Observations of the physical plant were not included in the first audit at CMS. Future audits will contain these observations and will be reviewed by the Consultant's Committee. Two issues that were identified by the Consultant's Committee include the need for modifications in the interview area in the medical unit at CMS. That renovation has not taken place and cost estimates are being received from architects at the present time. Also, the lack of air-conditioning within most of that facility. It was noted that Separation is air-conditioned but

the other cottages are not. Recently fire code requires that doors be closed at all cottages making the interior of those living units extremely uncomfortable during the summer months.
Recommendation: Build the wall in the CMS medical unit as recommended. Include physical plant observations in future audits.
UFN 4.4.4.1.5 determination of compliance with the facilities' policies, including those relating to: suicide prevention, staffing levels and youth supervision, use of force, disciplinary practices, positive behavior management programs, grievance procedures, sanitation, youth-on-youth violence, conditions in security units, adequacy of counseling and rehabilitative services, and the adequacy of all facility documentation; and
Status: Partial Compliance
Discussion: Policies are being re-written so they are measurable. This has been undertaken by the Office of Policy and Procedure, Marie Dils, Director. The policies and procedures that implicate and/or allude to the CRIPA agreement are included in one manual. There are 41 different policy & procedures outlined in the manual beginning with number 1050 and ending with policy number 4475.01. Each policy is stated, followed by definitions, rules and corresponding procedures. As each consultant undertakes his monitoring the policy and procedure is reviewed for adherence and subsequent compliance. Rather than attempt to summarize all of the areas listed in this UFN the monitoring for this section will be the updating and revision of policy and procedure by Ms. Dils and her staff and the corresponding audits conducted by the Quality Assurance Office for compliance with these policies and procedures and subsequently the settlement agreement.
Recommendation: Ms. Dils should provide to the consultants committee updates on any revisions to policy and procedure by area of settlement agreement responsibility. Those P&P should then be reviewed by the consultants for proper implementation consistent with the intent of the settlement agreement.
Documentation: No CRIPA Action Plan. Meeting with Mr. Veloz (prior to his re-assignment) and P&P staff during the first reporting period and reference to this manual of policy and procedure during the monitoring process.
UFN 4.4.4.1.6 A written report recording the findings of the audit.
Status: Partial Compliance
Discussion: To date one audit has been conducted at Catalina Mountain School on May 23-26, 2005. That report was issued by Megan McGlynn, Ph.D. Quality Assurance Administrator. The report was issued late in this reporting period.
Recommendation: Forward the CMS audit to the Consultants for their review and reference during subsequent site visits. An Executive summary of the audit findings compiled by section

consistent with the provisions of the settlement agreement would be very helpful.
UFN 4.4.4.2 Unannounced periodic site visits will occur at each facility. Investigations and Inspections Unit staff and the Quality Assurance Team shall have complete and unimpeded access to the facilities, their records, staff, and residents. Staff at the facilities shall be informed of their obligations to cooperate in all Investigations and Inspections Unit and Quality Assurance Team operations.
Status: Substantial Compliance
Discussion: The first audit conducted at CMS on May 23-25, 2005 demonstrated that the QA and I&I divisions will have complete and unimpeded access to the facilities, records staff and residents. During that audit the facility administration and personnel were completely agreeable to all requests for data, staff and youth interviews. This visit was not unannounced as indicated in this UFN but in order to maximize the effort and time of those involved the facility was notified of the visit and asked to prepare documents for inspection. Further audits will be conducted, Consultants will participate in some of those but will also have access to QA and I&I personnel for review of those audits as well as the official reports generated by those audits.
Recommendation: Discuss the issue of unannounced visits and whether those are intended to occur or to the extent that they do occur by either I&I and QA at the present time. Review findings of the AMS audit with the Consultants Committee.
Documentation: CRIPA Action Plan. Participation in CMS Audit of May 2005.
UFN 4.4.4.3 Investigation of significant incidents (as defined by the Administrator of the Investigations and Inspections Unit) shall include: Deaths; serious injuries or hospitalizations; suicides and serious suicide attempts; escapes or other serious breaches of security; and medical emergencies. The investigation shall result in a written report to the Director of ADJC and shall include findings and recommendations. The Director of the Investigations and Inspections Unit shall issue protocols for coordination of such investigations with other law enforcement, administrative disciplinary, or other quality assurance investigations.
Status: Partial Compliance
Discussion: The UFN Action Plan summarizes this process: All reports of deaths, serious injuries or hospitalizations; suicides and serious suicide attempts; escapes or other serious breaches of security; and medical emergencies that are a result of criminal activity and/or staff misconduct are sent to and investigated by trained and experienced investigators with supervisory oversight. Reporting sources are through the Youth Grievance System, the Zero Tolerance reporting system, and reports of staff misconduct reported by supervisors or staff. The administrative investigation Policy was written and implemented in October of 2004. The automated case management tracking system and electronic reporting and management system developed in November of 2004. The ADJC Director receives these reports directly from the I&I Administrator. In the 1 st report it was indicated that a weekly report going to the Deputy Director, Superintendents, Assistant superintendents and Captains was in development. The

intent was to track SIR's from assignment to findings, recommendations and resolutions. This process has been completed and is being utilized. Results of these investigations are part of the Youthbase data system available to authorized personnel.
Recommendation: Provide to the Consultants Committee a summary of the findings and recommendations from these investigations and implications for policy and procedure that affect this settlement agreement.
Documentation: CRIPA Action Plan submitted April 2005.
UFN 4.4.4.4 Review of all incidents of use of force and the use of separation in excess of 24 hours shall be conducted. The Investigations and inspections Unit shall be sent copies of every use of force report. The Administrator of the Investigations and Inspections Unit shall establish criteria under which such incidents shall be independently investigated for compliance with the facilities' policies. Such criteria shall include review of all incidents of use of force resulting in serious injury or hospitalization.
Status: Partial Compliance
<p>Discussion: All reports of excessive use of force (those that result in serious injury or hospitalization.) are electronically sent to I&I and investigated by that division. (See discussion in 4.4.4.3) Not all use of force is sent to I&I. The volume of such reporting makes this questionable since the application of handcuffs or use of hands to control a youth requires that a report be generated. A system that provides all of the necessary information on use of force and use of separation that exceeds 24 hours is still being developed</p> <p>The Investigations commander of the I&I Unit reviews allegations of excessive use of force. Cases assigned to an investigator are quality controlled by an automated review process that allows the commander to review the completed investigation and either returns the case for further investigation and/or accepts the conclusions/findings. Those reports were made available to the monitor for review. The inspection of separation logs-identifying placement in excess of 24 hours is being conducted by the Inspections Unit and documented in their Inspection's reports. This is conducted by the Chief Hearing Officer in the legal unit and an additional staff member from mental health.</p> <p>At the CMS audit conducted May 23-26, 2005 the separation unit was visited and logs reviewed by this monitor and Al Carpenter and Grady Daniels of the ADJC audit team. The separation unit documentation was generally legible and documented the use of separation. There were some errors noted on release times/dates. It was noted that Youthbase is used to log times in separation, but a standardized report has not been programmed to track potential problems.</p> <p>A quick review of Youthbase during the August site visit did show at least three youth who had been in separation in excess of 24 hours without a hearing being conducted.</p>
Recommendation: The Youthbase data tracking system should be enhanced and used to monitor youth release times and dates. (Part of CMS audit recommendation). The Consultants

Committee will need to continue to work with I&I and QA to determine accuracy of separation logs, verification of use of separation and any use beyond 24 hours. There is a need to review completed investigations for action justification. The issue of use of force reporting and system development needs to be discussed with the consultants during the next reporting period.
Documentation: CRIPA Action Plan, April 2005. Meetings with I&I Administrator John Dempsey and QA Administrator Megan McGlynn. Review of CMS audit report from QA dated May 23-26, 2005. Memorandum from John Dempsey of August 9, 2005. Discussion with hearing officers and juvenile ombuds.
UFN 4.4.4.5 Review of grievances raising significant issues (as defined by the Administrator of the Investigations and Inspections Unit) shall be conducted.
Status: Substantial Compliance
Discussion: Grievances that rise to the level of abuse/staff misconduct are routed to I&I for investigation. (See UFN 4.4.4.3 & 4.4.4.4.) The recommendation from the last reporting period is continued.
Recommendation: The resolution of these SIR's need to be more thoroughly examined during the next reporting period.
Documentation: CRIPA Action Plan.
UFN 4.4.4.6 When, through audits, investigations or other quality assurance activities, there are findings of substantial non-compliance with the requirements of the facilities' policies or this Agreement, a plan of correction shall be developed.
Status: Partial Compliance
Discussion: A plan of correction is part of the developmental process for both I&I and QA but primarily the QA office. Corrective action plans are included in the reports mentioned in 4.4.4.2. The QA office has begun its operation and the first audit, conducted at CMS, May 23-26 will be the first opportunity to review findings turned into corrective action plans. The reporting format calls for the Director, Deputy Director, Assistant Director of Secure Care, the appropriate facility Superintendent and the Quality Assurance administrator to document non-compliant issues and develop correction plans. The mechanism for tracking this is under development.
Recommendation: The Consultants Committee needs to review the findings of the CMS audit and subsequent audits to examine the corrective action plans recommended by the QA Office.
Documentation: CMS audit. Corrective action plan. CRIPA Action Plan.
UFN 4.4.5 ADJC shall hire sufficient numbers of qualified investigators for the Investigations and Inspections Unit to permit prompt and thorough investigations of all allegations of abuse, including incidents of violence, use of force, serious injury or sexual misconduct. ADJC shall

also ensure the investigators are provided initial and on-going training, and review and ensure the quality of all Investigations and Inspections Unit investigations.
Status: Substantial Compliance
Discussion: The structure of this office and its activities is contained in several CRIPA Action plans including this one (4.4.5. In addition there is information in UFNs 4.2.1 & 4.4.1). The ADJC is seen as in substantial compliance since this UFN refers directly to the establishment of the Office. The training is in place and is on-going. (See UFN 4.2.8). The monitoring of these activities will continue to determine the quality of these investigations in order to retain the substantial compliance rating.
Recommendation: The Consultants Committee will need to review the activities of this office focusing on completed investigations for quality assurance issues during this next reporting period.
Documentation: CRIPA Action plan. Review of completed and on-going investigations.
UFN 4.4.6 ADJC shall develop and implement policies and procedures specifying that abuse investigations may be initiated by Investigations and Inspections Unit staff's review of grievances, incident reports, use of force reports, and injury reports when it appears that abuse may have occurred but was not reported. Abuse investigations also may be initiated by Investigations and Inspections Unit staff as a result of staff tours of facilities and interviews with youth, parents, or staff.
Status: Substantial Compliance
Discussion: ADJC has developed the policies and procedures for the functions listed. The General Operating Policy Manual lists those as 1160 through 1165.04. The administrative investigation policy was written in order to outline processes and protocols for administrative investigations. The I&I Administrator is required to report these directly to the ADJC Director. Since the last reporting period additional training has been provided and the I&I appears to be adequately staffed.
Recommendation: The Consultants Committee needs to review current and completed investigations with special emphasis on any investigations that were initiated as a result of facility inspections or interviews with youth staff or parents.
Documentation: CRIPA Action Plan
UFN 4.4.7 The Administrator of the Investigations and Inspections Unit shall issue policies and procedures regarding steps that must be taken upon the reporting of an allegation of abuse in order to preserve evidence and protect youth pending an Investigations and Inspections Unit investigation.

Status: Substantial Compliance
Discussion: P&P 1160.05 discusses the rules and procedures that an ADJC employee, volunteer, intern, and/or service provider under contract with ADJC shall take if they reasonably believe that a minor is or has been the victim of abuse. Policy specifically requires that a staff member who is under investigation for allegations of excessive force be placed on ‘no youth contact’ status until the investigation is completed. Policy No. 1160.01.16. Evidence is preserved in the manner described in detail in the 1 st Semi-Annual Report. (Drop boxes in each facility controlled by I&I). The recommendation from the 1 st Semi-Annual Report is continued.
Recommendation: Prepare a listing of any youth moved for protection purposes so that the Consultant’s Committee can interview those youth.
Documentation: CRIPA Action Plan, April 2005. Policy & Procedure listed above.
UFN 4.4.8 The Administrator of the Investigations and Inspections Unit shall develop and implement an Investigations Manual and training program for abuse investigations. The Training shall include specific instruction by qualified individuals on the conduct of abuse investigations relating to youth, and investigations within a correctional setting, and shall include an annual in-service training requirement.
Status: Substantial Compliance
Discussion: The manual, “Multidisciplinary Protocol for the Investigation of Child Abuse”, as referenced in the 1 st Semi-Annual Report is the official reference. In addition, a protocol agreement between all the multi-disciplinary professionals (doctors, attorneys, CPS, forensic interviewers) involved in child crimes investigations has been adopted by the law enforcement community. The investigators at ADJC follow that protocol. APOST requires continuous training for Police Officers assigned to the unit in order to maintain APOST certification.
Recommendation: Develop, with the Consultant’s Committee, a content analysis of this training. Review current investigations for compliance to protocols mentioned in the discussion.
Documentation: Review of protocols with John Dempsey, I&I Administrator. CRIPA Action Plan, April 2005.
UFN 4.4.9 The Administrator of the Investigations and Inspections Unit shall ensure that the Investigations Manual contains guidance and information regarding the following requirements:
UFN 4.4.9.1 An interview with the alleged victim and perpetrator:
Status: Partial Compliance
Discussion: The I&I manual contains the protocol for these interviews. This protocol is currently being revised and tested. They are from the “Multidisciplinary Protocol for the Investigations of Child Abuse” that guide I&I investigators.

Recommendation: Provide the Consultant's Committee with the most recent summary of the revisions of this manual and the reasons for those revisions.
Documentation: Review of manual. Discussion with John Dempsey, I&I Administrator and Grady Daniels, ADJC Legal Division. Policy number 1160.05 and 1160.04.4
UFN 4.4.9.2 Identification and interview of all possible witnesses, including other youth and staff in the building or unit at the time of the incident;
Status: Partial Compliance
Discussion: This UFN has not changed. The time frame has not allowed this level of detail. It is expected that this UFN will be thoroughly reviewed during the next reporting period. The protocol is in the manual but under review and revision. A review of incident reports and investigations does document witness interviews.
Recommendation: Develop a listing of witness interviews for review and schedule interviews with witnesses in recent investigations for the next reporting period.
Documentation: I&I manual, discussions with John Dempsey, I&I Administrator and Grady Daniels, ADJC Legal Division.
UFN 4.4.9.3 Examination of the youth and staff member's institutional and personnel records, including any prior allegations of abuse against the staff person whether substantiated or not;
Status: Partial Compliance
Discussion: The Employee Information Sharing System (EISS) is being installed. This will provide an Early Warning component that better manages employee behavior. Supervisors can use this system to help identify possible problematic behaviors and or incidents that attribute to such behaviors. This procedure is included in the I&I manual. This is also under review and revision. The recommendation from the 1 st Report continues:
Recommendation: Remains the same from the first report. Update the Consultant's Committee on the revisions of the protocol and provide examples of review of staff and youth who were identified as abusers based on this procedure.
Documentation: EISS protocol. CRIPA Action Plan. Policy 1160.04.6.a&b.
UFN 4.4.9.4 Examination of any potentially relevant medical records; and
Status: Partial Compliance
Discussion: The I&I Manual contains the P&P . The I&I is currently doing this but this needs to

be examined by the Consultant's Committee.
Recommendation: Provide an update to the Consultant's Committee by I&I of its revision to this manual and any examination of medical records in investigations.
Documentation: Discussion with John Dempsey I&I Administrator and Grady Daniels, ADJC Legal Division. Policy 1160.04.5&6.
UFN 4.4.9.5 Determination whether any facility staff knew of but did not report the alleged abuse, or provided false information during the investigation.
Status: Partial Compliance
Discussion: The Employee Misconduct policy, addresses this issue and details the violations. This was very recently approved by Director Branham and will be more extensively reviewed during the next reporting period.
Recommendation: The Consultant's Committee will need to look at completed investigations and work with I&I to determine how this information is being developed.
Documentation: Policy numbers: 2003.04.2g; 2003.04.3h; 2003.04.3.5; 2003.0405.c; 2003.04.5c; 2003.04.9.c; 2003.04.13.b; 2003.04.13.h. Memo from John Dempsey of August 9, 2005.
UFN 4.4.10 The Administrator of the Investigations and Inspections Unit shall continue to ensure that a written report of each investigation of an allegation of abuse is produced. The report shall describe steps taken during the investigation, the information obtained, and the factual conclusions reached by the investigators finding the allegation substantiated, not resolved or unfounded. The Investigations and Inspections Unit shall continue to keep records of all of its investigations, and any disciplinary action taken in response to the investigation, including investigations that do not substantiate abuse.
Status: Substantial Compliance
Discussion: The I&I automated reporting system tracks all allegations of abuse. This is also backed up by a hardcopy file. With the completion of the AIR (Administrative Incident Reporting System) personnel will track the disciplinary disposition of each investigation conducted and it will track all allegations of staff misconduct (lower level violations).
Recommendation: During the next reporting period review the AIR system with I&I personnel. Connect allegations of staff misconduct with investigation results.
Documentation: Discussion of AIR system with John Dempsey, I&I Administrator and memo from John Dempsey of August 9, 2005 clarifying status of AIR.
UFN 4.4.11 The Director of ADJC, upon receipt of an investigative report for allegations of

abuse, shall approve or disapprove the report's conclusion that the allegation was substantiated, not resolved or unfounded, or shall order further investigation. Only the Director of ADJC shall have the authority to disapprove a report's conclusion that the allegation of abuse was substantiated. In such cases, the Director must explain the reason for such a decision in writing for personnel reasons. ADJC shall ensure that prompt and appropriate personnel actions are taken in response to substantiated findings.
Status: Partial Compliance
Discussion: Material was requested to review this UFN but not received. This process is occurring but documentation has not been reviewed.
Recommendation: Need to connect investigations and personnel actions for verification during the next reporting period.
Documentation: Discussions with John Dempsey and Director Branham
UFN 4.4.12 ADJC shall develop and implement policies and procedures to address management problems that are uncovered during the course of an Investigations and Inspections unit investigation (e.g., inadequate staffing, location of abuse or fights, etc.). Corrective action plans will be developed to address these problems in an effort to prevent them from reoccurring,
Status: Partial Compliance
Discussion: The first audit conducted at CMS May 23-26 does contain recommendations for changes in policy and procedures based on findings developed through the audit. Corrective action plans will be the outcome of the recommendations. The plans, at the writing of this report, have not been completed. During the next reporting period the recommendations from audits that have been conducted will be connected to action plans and then monitored for implementation.
Recommendation: Develop a process that monitors recommendations from audits to corrective action plans, including dates of corrective action.
Documentation: CMS audit of May 23-26, 2005

4.5 Disciplinary Confinement/Due Process

UFN 4.5.1 The DOJ acknowledges that the State has enacted policies and procedures regarding the use of exclusion, in-room confinement, lock down, large group, or other such restrictions to ensure usage when strictly appropriate consistent with facility security. The State shall continue to implement those policies and procedures, and shall monitor those policies and procedures for compliance, as described in 4 (c) and 4 (d) above.

Status: Partial Compliance

Discussion: A portion of the team that participated in the Technical Assistance Visit to Catalina Mountain School, Al Carpenter, Grady Daniels and Russ Van Vleet spent one morning of this visit in the Separation unit. The separation Unit log was reviewed in detail. Two youth were in separation at the time of the visit. From January '05 to May 24, '05 counts ranged from 3 to 0 on most days. The lone exception was March 1, '05 when 10 youth were in Separation. By the next day 9 of the 10 had been returned to their cottages. On March 28 the count jumped to 7. The next day the count was again down to 1. On April 4th the count went to 7. On April 5 the count was down to 2. We then verified that these 2 youth, since they were held longer than 24 hours, did have hearings. At this point we tried to pull up the Youthbase Data System to track the youth in Separation and found that the youthbase summary on Separation had no data in it. This system would be critical for verification of the use of Separation so the data entry issue needs to be resolved. While at Separation reviewing the log with the cottage supervisor two more youth were brought in. The entry time is noted on a board and if the Incident Report is not received within 90 minutes the youth are released back to their cottage. One youth was booked into the facility at 13:10 and released at 14:50 due to no IR being delivered to Separation. This does raise an interesting issue to continue to monitor. The number of youth being released within the 90-minute period? Need to determine to what extent Separation is used for a 90-minute separation from the cottage and its relationship, if any, to the use of exclusion/isolation in the cottages.

Another issue raised during this review was the differences in logs and missed entries. On 3/27, '05 a youth should have received a hearing but the log did not show that a hearing was held. Also no release date was entered for that particular youth. On 3/28 another discrepancy was found in an entry. A hearing that was held was not entered in the log. The logs were very difficult to read. Staff write the entries and sometimes the writing is barely legible. In addition, in checking the Youthbase data system we found that two hearings that were held were not entered into the youthbase data system. One final issue from Separation; We actually found a discrepancy in the count. The log said 8 youth when the actual count was 4. We checked with central control on the official count for the facility and it was correct. The checks and balances in place within that office took care of the discrepancy but it does point out the need for more attention to the log, if it is to be considered valid documentation of cottage activity.

During the May 23-25 Technical Assistance visit by the Offices of Quality Assurance and Inspections and Investigations at the Catalina Mountain School, Al Carpenter, Grady Daniels and Russ Van Vleet went from cottage to cottage checking logs and talking to staff to determine how each cottage uses exclusion/isolation.

May 24. Aegeis review of the use of exclusion. This cottage utilizes a “Bump” log. BUMP is the name for exclusion in this unit. Between February 1 and May 6th (last entry when we were there) there were 28 instances of “bumps” or use of exclusion. The log did not keep time in or out of BUMP. In BUMP an assignment is given to the youth that the youth must complete. The policy states that exclusion shall not exceed 2 hours. However, when talking to the staff on duty at the time he indicated that there is no time frame for “BUMPS”. Staff indicated that when youth are placed on BUMP status no time frame is given to them. Staff usually follows the recommendation of the staff member who placed the youth on BUMP status and this time frame may exceed 2 hours. When asked about 15 minute checks the staff indicated that this was not occurring.

May 24. Mesquite Cottage: Last log entry shows 6 youth in exclusion from 3/27 to 5/23. The logs were incomplete. In some instances the time of exclusion was not recorded, in some instances times the youth was checked on not recorded, in some instances time taken out of exclusion was not recorded. Only 1 of 6 entries had the times entered for all three categories. (Time of exclusion, times checked and time out of exclusion). On individual notes for the youth we found the entries but on the log summary they were not entered. In this cottage the management technique utilized is called “Reflection”. Reflections was described, by various staff we met, as not a good or bad status. It is viewed as a very important cottage management tool. Senior staff interviewed were clear that exclusion is not punishment, and that reflection is a way to help youth deal with their issues and manage the cottage. Walking through the cottage one can see red tape on the entryway of various parts of the cottage that say “reflection.” Meaning that if the youth enters that part of the cottage without permission it is automatic “reflection.”

May 24. Manzanitas cottage: The documentation on the use of exclusion was similar to Mesquite. The forms were not always completely filled in. Entries noting time of exclusion, room checks, time out of exclusion were not always completed. Actually, staff indicated that the 15-minute reports were very important since they were to be “interactions” not just checks. It was this interaction with the youth that determined removal from exclusion status. Once again, individual entries on youth were more complete than the Unit log. These pieces of information, however, are important. Without the time entries there is no ability to monitor the frequency or duration of the use of exclusion. Excessive lengths of stay may be a result of this. Further monitoring will have to address this issue.

During the last reporting period it was indicated that five procedures were scheduled for re-write and revisions. Those re-writes include a new exclusion policy that was being implemented during our July site visit. This policy is contained in Appendix C.

The CMS audit conducted May 23-26, 2005 also contains a section on Isolation/exclusion/separation, policy 4064. Excerpts from that audit are useful because they do illustrate the issue confronting ADJC in this area:

(1) Definition of exclusion not clear in documentation. Also called time-out, isolation, bump, reflection, vacation. Any of these terms means a youth is removed from regular programming for different reasons.

- (2) Documentation of youth on exclusion/isolation not present, except in separation unit.
- (3) Housing units could not produce documentation of youth checks every 15 minutes for youth removed from programming.
- (4) Interviews with staff revealed that the definition of exclusion is not clear.
- (5) Some staff used exclusion as punishment, some reported that they were not required to document 15 minute checks on youth on exclusion, unless they were on a close observation status.
- (6) Staff from all units were interviewed about isolation and exclusion, the responses were very different and most staff would state something to the effect "this is how we do it in our unit".
- (7) It was clear from the interviews that there was not a consistent way to implement, document or supervise exclusion and isolation.

In the de-briefing held with Director Branham and his staff at the conclusion of the July site visit considerable concern was expressed about the lack of a coherent exclusion policy. Also, the various interpretations of cottage management policy utilizing exclusion as a main component of that policy being utilized by cottages in the 3 ADJC facilities visited.

In response to that visit, Director Branham conducted a visit to the same cottages in order to determine what action would need to take place in order to appropriately respond to the concerns voiced at the de-briefing. The findings from that visit are as follows:

Site visit by ADJC of July 20, 2005

Success Cottage-Approximately 65% of staff trained on new exclusion procedure effective 7/1

Exclusion Positive

Using Close Obs form

15 minute checks documented

One staff interviewed articulated exclusion

Exclusion Negative

In & out times not noted in unit log

Close Obs forms not signed by manager

LSI form not attached

"No Exclusion" list not posted

1 exclusion period beyond 1 hour

Old exclusion period beyond 1 hour

Old exclusion form attached to new form (redundant documentation)

Log Books

Unit Log-Current, legible, in chron order, appropriate.

Communication Log-dated to 2003, duplicative with memo book, poorly maintained

Venture Cottage

Exclusion Positive

Using Close Obs form

In & out times noted in unit log

15 minute checks documented

“No Exclusion” list posted

Exclusion Negative

Close obs forms not signed by manager

LSI form not attached

Old exclusion form attached to new form (redundant documentation)

Log Books

Unit Log-current, legible, in chron order, appropriate.

Communication log-not reviewed

Maya Cottage

Exclusion Positive

Using Close obs form

In & out times noted in unit log

15 minute checks documented

“No Exclusion” list posted

Some LSI forms attached

All close obs forms signed by manager

Two staff interviewed articulated purpose of exclusion appropriately

Exclusion Negative

Some LSI forms not attached

Log Books

Unit Log-current, legible, in chron order, appropriate

Communication log-current, appropriate

Recovery Cottage

Exclusion Positive

Using Close obs form

In & out times noted in unit log

15 minute checks documented

Exclusion Negative

Close obs forms not signed by manager

LSI form not attached

“No Exclusion” list not posted

Exclusion log appears to have been re-done yesterday morning-not two weeks ago.

Log Books

Unit log-current, legible, in chron order, appropriate

Communication Log-current, appropriate

In response to the de-briefing and the site visit conducted by Director Branham and his leadership team the following was ordered:

- 1- Consolidate unit and communication logs in to a single book.
- 2- Review exclusion procedure-ensure exclusion usage is consistently reviewed by a manager, taught and practiced with all line staff for consistency.
- 3- The formation of a three person housing unit group life training team. Their mission will be to ensure that all applicable housing unit policies and procedures, including new training on exclusion and grievance procedures are well understood and established by all unit staff. In addition, the team will address the daily cultural and programming activities that should be incorporated in the unit milieu. The “hands-on” training sessions will follow on the heels of the formal classroom training that began in March 2005.
- 4- Youth Grievance oversight. Sheila Press will be assigned to review all grievances for the next 30-45 days and will solidify practice of finalizing and solving all written grievances with concrete action plans. Our practice will be that all grievances will be completed through formal action oriented plans.
- 5- Improved internal communications. A new employee newsletter “ADJC Today” was provided as a payroll stuffer. The newsletter will be offered every two weeks so that every ADJC employee becomes well-informed with agency operations, special events, and other relevant information. Also, an electronic employee bulletin board was installed. This will allow employees to post personal-type announcements.

The exclusion policy, 4064, effective 06/15/2005 is listed in Appendix C

On August 11th and 12th, Consultant Van Vleet and Director Branham made an unannounced site visit to AMS and BCS to determine if the changes had been successfully installed. Four of the five changes ordered were able to be verified as part of this visit. Logs books were consolidated, the exclusion policy was clearly stated, visible and understood by employees (employees were queried as to exclusion policy and procedure as part of the visit), the three person team (which was part of the changes ordered, see above) was active and interviewed to ascertain the level of their activity. It was confirmed that Sheila Press was providing the grievance oversight. The newsletter was not yet published at the time of the visit but will be reviewed during the next reporting period.

Recommendation: It is recommended that ADJC commit to proper maintenance of logs in all cottages. Proper and complete entries that are legible. That youthbase be reviewed for adequacy in capturing use of exclusion. During the next reporting period ADJC should convene a meeting with senior cottage staff, MH leadership and the consultants to discuss the implementation of the exclusion policy and to determine if the use of exclusion, as practiced in individual cottages, is consistent with policy 4064. The relationship between adequate techniques or managing youth within the cottage and the concern with the exclusion of youth and the attendant concerns such exclusion practices contain must be more thoroughly reviewed. The pre-service training within the Academy and its emphasis on the use of effective group management techniques also needs further review.

Documentation: Technical Assistance site visit to CMS on May 23-25, 2005. Interviews with staff and youth. Review of logs in each cottage visited as well as a review of entries in the youth base data system. July site visit to AMC, BCS. Debriefing with ADJC leadership team. August Site visit to AMS and BCS. Memo from Jim Hillyard to Dianne Gadow dated July 21, 2005, 12:48 p.m.

UFN 4.5.2 The State shall continue to ensure that youths confined in Separation for more than 24 hours receive a due process hearing by an impartial official to determine whether cause exists for continued confinement.

Status: Partial Compliance

Discussion: The Youthbase system was reviewed. It has been changed to identify any youth staying in separation longer than 24 hours and to reflect that a hearing was held within the allotted time frame. During the site visits youth were identified (in the youthbase data system) who had stayed more than 24 hours and several had not had hearings within the required time frame. (Once youth are identified as having stayed 24 hours they are released from separation. Hearings, at that point, are not held, the hold in separation is simply terminated.)

In addition, the youth ombuds was interviewed at each facility and indicated a thorough knowledge of this issue and they make it a top priority of their workday. Youth in separation are carefully monitored by the separation supervisor. Separation supervisors were interviewed at CMS and BCS, their logs checked and verified hearings for those youth staying more than 24 hours. .

The recommendation in this section remains the same as in the 1st report. ADJC is in Partial compliance with this UFN. Separation staff are very conscientious about the time frames yet youth base does record youth who did not have hearings. As the recommendation indicates, the monitoring of this provision did identify another issue, that being the use of separation for shorter periods of time and the need of ADJC to determine the propriety of that use.

Recommendation: The policies and procedures governing this area need to be revised to require that staff that initiates separation meet with the youth in a short time period. (Within the first hour. In most instances the separation is only necessary for a very short period of time.) Separation reports indicate that most youth spend less than 24 hours in separation and nearly 50% spend less than 4 hours. It would seem that the report ought to look at youth who are returned within the first hour. Also a reconciliation of youthbase data that reflects youth staying without hearings with interviews with separation staff that indicate that has not occurred.

Documentation: CRIPA Action Plan,. Interviews with staff, youth. Observation of procedures during the CMS audit of May 23-26,2005.

5. SPECIAL EDUCATION

UFN 5.1 The State shall at all times, provide all youth confined at the facilities with special education services as required by IDEA, 20 USC sec 1400 et seq., and regulations promulgated thereunder, Section 504 of the Rehabilitation Act of 1973, 29 USC sec 794, and regulations promulgated thereunder, and this agreement.

Status: Substantial compliance.
Discussion: The ADJC continues to improve service delivery in special education. Discussion of various areas of compliance follows.
Recommendation: During the second reporting period, the Consultants examined Arizona Department of Education monitoring reports, discussed current status of education with the Superintendent and the Director of Special Education for ADJC. The Agency has made substantial progress in addressing the provisions in this section. The status of provisions in this section reflects the improvement in services. While a number of provisions were not reviewed during the first reporting period, only three items were rated as “substantial compliance” in the last report. In contrast, the Consultants’ Committee found 14 provisions in compliance during this second period. Discussion and documentation follows.
Documentation: Review of notes, monitoring reports, observations of classes, and review of files.
UFN 5.2 The State shall retain a Superintendent of Education who shall meet the minimum standards as specified by the State. The State shall provide the Superintendent with sufficient staff and resources to perform the tasks required by this Agreement, [including...]
Status: Substantial compliance
Discussion: Dr. Judith Lanphar, Superintendent of Education, continues to monitor the adequacy of resources and staffing essential for the State to maintain compliance with the Settlement Agreement. She has moved quickly to identify vacancies and has worked closely with human resources personnel to post job vacancies as soon as is possible.
Recommendation: During the next reporting period, the ADJC education program should identify for the Consultants’ Committee, a projection of staffing and resources for each of the three secure facilities covered by this Agreement along with strategies to ensure that sufficient staff and resources are sustained over time.
Documentation: Review of documents, classroom observations, interviews with staff.
UFN 5.2.1 Oversight of the special education programming in the facilities, including development and implementation of policies and training programs.
Status: Partial Compliance.
Discussion: During the second reporting period, the Superintendent of Education developed a number of draft policies designed to ensure that practices consistent with the Settlement Agreement became part of the culture and practice within the Agency and the schools.
Recommendation: The ADJC education program has a school schedule with an intensive array of staff development activities. Many of these activities are designed to ensure that ADJC

teachers provide instruction and support consistent with State and Federal guidelines for education. Several policies are waiting final approval from ADJC administration.
Documentation: Review of draft policies, discussions and meetings with the Superintendent of Education.
UFN 5.2.2 Monitoring whether special education staffing and resources are sufficient to provide adequate special education services to youth ... and to ensure compliance with this agreement;
Status: Substantial compliance
Discussion: The Committee discussed adequacy of staff and resources with principals at AMS, BCS, and at CMS as well as with Superintendent of Education Dr. Lanphar. The Committee continues to have concerns about ADJC's ability to retain well-qualified teachers. Half of the proposed 5K stipends for special education teachers are scheduled to be distributed in the fall of 2005. This action will in the short term help the Agency retain special education teachers. Other proactive measures that include revising the school calendar and aggressive recruiting may be necessary in the long run.
Recommendation: ADJC continues to be proactive about filling staff vacancies.
Documentation: Review of "action plans" developed by the Superintendent of Education, discussion with principals, observation of classrooms, interviews with youth
UFN 5.2.3 Development and implementation of a quality assurance program for special education services.
Status: Partial compliance
Discussion: During the reporting period, the Consultants' Committee observed the QA review of files for youth in the RAC at AMS. The QA process for education appears to be in development.
Recommendation: Review the results of the QA audits with the Deputy Director and Dr. Lanphar. In areas where there is substantial room for improvement, develop an action plan tailored to the specific deficiencies.
Documentation: Observation of QA audit at AMS/ RAC, discussion with Dr. Megan McGlynn, review draft QA policy for education.
UFN 5.3 The Superintendent shall provide prompt and adequate screening of youth for special education needs and shall identify youth who are receiving special education in their home school districts or who may be eligible to receive special education services but have not been so identified in the past. Such procedures shall include:
Status: Partial compliance

Discussion: ADJC education staff have developed a number of forms for review of “out-of-district” psychoeducational evaluations, review of the Arizona Department of Education (ADE) monitoring reports, and policy and procedures for special education and child find documents. At AMS the “child identification” process was rated as “in compliance” by ADE.
Recommendation: Implement the Corrective Action Plans for BCS and AMS as submitted to the ADE. Insure that the site coordinators (see UFN 5.7.5) participate in the development of remedial measures in response to this and other issues.
Documentation: Review of screening form and student files
UFN 5.3.1 Guidelines for interviewing youth to determine past receipt of special education services;
Status: Substantial compliance
Discussion: The education program continues to implement the interview protocol developed earlier this year. The interview is administered as part of the RAC process at Adobe Mountain School.
Recommendation: Continue to include the interview protocol as part of the Reception Assessment Center intake process.
Documentation: Review of intake interview form, interviews with youth, discussion with Dr. Lanphar.
UFN 5.3.2 Protocols developed in conjunction with local school districts and the State Department of Education for expedited reporting of special education status of students entering the facilities, conducting adequate testing of youths’ substantive educational knowledge, and performing necessary vision and hearing tests;
Status: Partial compliance.
Discussion: Students’ files showed evidence that records from prior schools students attended were being sent to ADJC. The ADJC Education program has developed a good system of communicating with juvenile detention centers, particularly those in Maricopa and Pima Counties.
Recommendation: During the next reporting period the Committee will continue to discuss procedures used to expedite retrieval of information about students’ prior school status. Steps to strengthen the connection between ADJC and local school districts will be reviewed.
Documentation: Review of prior school records in students’ files, discussion of contacts among ADJC, the AZ Department of Education, and local school districts.
UFN 5.3.3 Procedures identifying criteria under which staff or teachers must refer a student for

evaluation for special education eligibility, including identifying criteria under which youth whose behavior has led to repeated exclusion from class must be referred for evaluation;
Status: Substantial compliance
Discussion: Serious and persistent misbehavior in class can be associated with significant academic deficits. When developed these procedures will help ensure that thorough psycho-educational evaluations are conducted on students who need it.
Recommendation: The special education director should confer with teachers and principals and draft a set of procedures that can be reviewed during the next reporting period.
Documentation: Review of referral forms and discussions with teachers about referral of students not previously identified as eligible for special education.
UFN 5.3.4 Policies describing the required activities of Student Support Team pre-referral and support team functions;
Status: Partial compliance
Discussion: Student support teams can assist teachers and related professionals determine how to ensure that all students succeed. Well developed teams can prevent unnecessary referrals to special education and minimize behavioral problems.
Recommendation: The Superintendent for Education has drafted policies and procedures for the student support teams at each institution. Discussion with staff suggests that the process is working at some of the schools. Full implementation of support team policies and practices is anticipated during the next review period.
Documentation: Discussion with teaching staff and school principals.
UFN 5.3.5 Policies describing the requirements for comprehensive evaluation procedures to determine eligibility for special education services;
Status: Substantial compliance
Discussion: Comprehensive evaluations help determine who is eligible for special education services and help pinpoint students' needs. The ADJC education staff have developed and distributed guidelines to diagnosticians and school psychologists working at the three facilities covered by the Settlement Agreement.
Recommendation: The special education director has developed policies and procedures for comprehensive evaluations consistent with Arizona Department of Education and federal guidelines.
Documentation: Review of policies and directives to staff from Superintendent Lanphar and

Special Education Director Jacobs.
UFN 5.3.6 Policies describing the criteria for multidisciplinary team decision-making regarding eligibility for special education.
Status: Substantial compliance
Discussion: The Consultants' Committee met with the Superintendent for Education and the Director of Special Education and reviewed ADJC Procedure 4475.03. This new policy, effective as of 4/12/05 describes criteria for determining eligibility and interpreting evaluation data.
Recommendation: During the next reporting period, the ADJC education program should periodically monitor successful implementation of these procedures to ensure continued compliance in this area. This task can be completed as part of the provisions for quality assurance review (UFN 5.3.2 and 5.9.2).
Documentation: Review of new policy, discussion with Dr. Jacobs and Dr. Lanphar.
UFN 5.4 The State shall continue to ensure that qualified professionals participate in the process for determining special education eligibility as required by federal regulations.
Status: Substantial Compliance
Discussion: The Consultants' Committee reviewed 13 students' files to identify who participated in MET/IEP meetings. It appears that appropriate professionals from mental health and custody staff participate in the development of students' education plans.
Recommendation: Ensure that qualified professionals including Youth Care Officers continue to be invited to participate in discussions of special education eligibility.
Documentation: Review of students' IEPs.
UFN 5.5 The State shall continue its collaboration with the Arizona Department of Education to ensure appropriate parent guardian or surrogate parent involvement in evaluations, eligibility determinations, placement and provision of special education services.
Status: Partial compliance
Discussion: The Consultants' Committee examined IEPs for evidence of surrogate parent participation. Discussions with Dr. Lanphar and Dr. Jacobs indicate that recruiting surrogates has been a challenge but several have been assigned and are working with ADJC.
Recommendation: During the next reporting period, the Director of Special Education should report on the number of surrogates trained and the number currently serving and/or available to serve youth.

Documentation: Review of IEPs, discussion with Dr. Lanphar and Dr. Jacobs.
UFN 5.6 ADJC shall continue to ensure that if a youth is discharged from the facilities before the completion of the educational evaluation required above is complete, ADJC will forward to the superintendent of the youth's receiving school district all information regarding screening and evaluations completed to date, noting what evaluations are yet to be performed.
Status: Partial compliance
Discussion: Most information gathered concerning this provision was anecdotal. Staff acknowledges the difficulty of transmitting information to schools as students leave receiving information from outside districts as students enter ADJC facilities.
Recommendation: During this next reporting period, the Superintendent should have a designated staff member follow-up on a sample of youth who have left each facility. For those youth with partially completed educational evaluations, determine whether follow-up phone calls and copies of relevant documents have been transmitted from ADJC to receiving schools or programs.
Documentation: Discussion with Dr. Lanphar and principals at AMS, BCS, and CMS.
UFN 5.7.1 ADJC shall, in a reasonable time period, create and/or implement an IEP, as defined in 34 C.F.R. § 300.340, for each youth who qualifies for an IEP. As part of satisfying this requirement, ADJC shall conduct required evaluations of IEPs, adequately document special education services, and comply with the IDEA regarding parent, surrogate, and student participation in the IEP process. ADJC shall hold team meetings once per week, if necessary, to develop IEPs for qualified special education students in accordance with federal regulations.
Status: Partial compliance.
Discussion: During this reporting period the Consultants' Committee reviewed 13 files including IEPs for students at AMS and BCS. The Committee also reviewed an internal special education service report for CMS and an internal audit for CMS. For the most part, IEPs developed appear to be consistent with the needs identified by psychoeducational evaluations. Students continue to participate in most all MET/IEP meetings and parents participated in some IEPs. The implementation of IEPs and provision of services at AMS and BCS appears to be consistent with youths' needs. At CMS the school staff struggles to effectively implement IEPs and the school program has experienced significant challenges. The internal audit of CMS special education service, observation of classrooms, and discussion with staff indicate that problems are being systematically addressed. Among other things, a new principal has been assigned to CMS during this reporting period and the special education program is being closely scrutinized by Dr. Jacobs. An essential part of IEP development is the role of the Educational Diagnostician. Currently ADJC has 4 Diagnosticians. These positions are located at each of the institutions and are responsible for ensuring that the educational requirements of IDEA are being met. These positions are currently funded with federal Title I grant monies. The Department has been notified by the Department of Education that the use of Title I monies for diagnosticians is an

inappropriate use of these funds. These positions are critical to Special Education monitoring. Therefore, in order to maintain compliance with federal IDEA statutes, the State must find funding for these critical positions.
Recommendation: During the next reporting period, the Consultants' Committee will review IEPs at CMS and examine files for youth receiving special education services. In particular, the Committee will examine the implementation of IEPs at this facility.
Documentation: Review of students' IEPs, and internal audit for CMS and the internal special education reports for AMS, BCS, and CMS.
UFN 5.7.2 In developing or modifying the IEP, ADJC shall ensure that the IEP reflects the individualized education needs of the youth. When the nature or severity of a youth's disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily, ADJC shall provide an appropriate alternate educational setting. ADJC shall ensure that each developed or modified IEP include documentation of the team's consideration of the youth's need for related services and transition planning. ADJC shall employ or contract with appropriate professionals to ensure the timely availability of related services to youths in the facilities.
Status: Substantial compliance
Discussion: During this reporting period, three boys at AMS, one girl at BCS, and four boys at CMS were interviewed. With some exceptions, students made positive comments about the education services they received, particularly at Adobe Mountain School and Black Canyon School. The new vocational programs being implemented at all three institutions will round out the curricular offerings available to youth and help ensure that youth have a range of courses available to meet their needs.
Recommendation: Continue to develop connections with community-based programs including technical schools and other post-secondary training and employment opportunities.
Documentation: Interviews with youth, review of 13 IEPs and related documents, and discussions with teachers, and administrative staff.
UFN 5.7.3 The Superintendent shall continue to develop and implement a system to promote parent, guardian, and surrogate involvement in IEP development and placement meetings. This shall include such meetings through telecommunications technology or during times reasonably calculated to accommodate the schedules of parents, guardians, or surrogate parents. ADJC shall post notices in each facility stating the rights of students, parents or guardians regarding education services, including special education services.
Status: Substantial compliance.
Discussion: Of the 13 IEPs reviewed, parents and/or surrogate participated in some of the meetings at ADJC facilities.

Recommendation: Parents appear to be attending IEP meetings. Less frequent is evidence that surrogate parents attend the meetings. ADJC is encouraged to continue to work with the ADE to have access to a pool of persons qualified to serve as a surrogate when parents are unable to attend meetings.
Documentation: Review of IEP files, discussion with Dr. Gail Jacobs, Special Education Director, ADJC.
UFN 5.7.4 The Superintendent of Education shall develop and implement an education staffing plan to ensure adequate staff to comply with the terms of this agreement. The plan shall provide for...
Status: Partial compliance.
Discussion: The Consultants' Committee reviewed current staffing plans and discussed staffing with Superintendent Lanphar. Currently there are a total of 14 teaching vacancies at AMS, BCS, and CMS. Current salary and school calendar for ADJC education program make it difficult to attract and retain high quality teaching staff.
Recommendation: ADJC Education program is encouraged to work with the Department of Administration, the human resources office within ADJC, and the Office of the Director to analyze disincentives associated with teaching within the ADJC facilities.
Documentation: Discussion with Dr. Lanphar and review of the organization charts for AMS, BCS, and CMS including a list of current vacancies.
UFN 5.7.4.1 Sufficient numbers of certified special education teachers and staff to provide all youths with the opportunity to attend school full-time and to obtain adequate educational services, and to provide teachers with sufficient time to plan lessons, grade assignments, and participate in special education meetings;
Status: Partial compliance.
Discussion: The current teaching vacancies include two special education teachers. Inadequate numbers of special education teachers will make it difficult to achieve and maintain compliance.
Recommendation: During the coming reporting period, ADJC special education teachers are scheduled to receive the first half of the retention monies designed to keep qualified teachers on staff.
Documentation: Interviews with teachers at CMS and AMS and with principals at AMS, BCS, and CMS. Review of ADJC organization charts listing teaching vacancies at the three facilities included I the Settlement Agreement.
UFN 5.7.4.2 Sufficient psychological services to provide psychologist participation in the IEPs, administration of psycho-educational assessments, consultation with teachers and staff, and

individual counseling related specifically to issues in youths' IEPs and educational plans.
Status: Substantial compliance.
Discussion: The Education Program has had a new psychologist position filled. Contract psychologists and an ADJC clinical psychologist also provide services to ensure youth are assessed in a timely manner.
Recommendation: Continue to have several options available for assessment of youth.
Documentation: Discussion with Dr. Lanphar and Dr. Jacobs.
UFN 5.7.5 ADJC will continue to designate an individual at each facility who is responsible for ensuring compliance with all provisions in this Agreement related to special education services.
Status: Partial compliance
Discussion: The Consultants' Committee discussed special education compliance issues with Dr. Lanphar, Dr. Jacobs, and with the principals at AMS, BCS, and CMS.
Recommendation: While special education service delivery continues to improve at each site, much of the impetus for change is coming from Dr. Jacobs and the central office. Designated staff at each school should take a more proactive role in ensuring the school is in compliance.
Documentation: Discussion with principals at AMS, BCS, and CMS.
UFN 5.8.1 The State shall ensure that appropriate Section 504 plans are developed for all eligible youth. The State shall employ two Section 504 coordinators/guidance counselors at Adobe Mountain and one such position at each of the other facilities to develop and implement ADJC's Section 504 program and provide additional educational counseling services to youth.
Status: Substantial compliance
Discussion: Internal documents reviewed by the Consultants' Committee indicate that a Section 504 coordinator/guidance counselor has been hired for the Reception and Classification unit (RAC) at Adobe Mountain School. Candidates have been interviewed for the second position at AMS and for the vacancies at CMS, and BCS.
Recommendation: If it has not done so already, during the next reporting period the education program should review and report on the frequency with which Section 504 plans are developed at each of the three secure care facilities included in this agreement. The Consultants' Committee will review with the Superintendent of Education and/or the Special Education Director the 504 coordinator/guidance counselor positions and processes.
Documentation: Discussion with Dr. Jacobs and reviewed internal special education audits.

UFN 5.9.1 The Superintendent of Education shall continue to design and implement annual in-service training requirements for special education staff of not less than four times per year, to enhance their ability to implement their duties under the provisions of this agreement.
Status: Substantial Compliance
Discussion: The Education Superintendent and her staff have developed an extensive set of in-service activities and have made on-going staff development a high priority.
Recommendation: The ADJC education program should report on the evaluation of training activities.
Documentation: Review of intersession schedules and school calendar, discussion with Dr. Lanphar and Dr. Jacobs.
UFN 5.9.2 The Superintendent of Education shall be charged with quality assurance of all special education services at all of the facilities. The Superintendent of Special Education shall, in coordination with the ADJC Quality Assurance Team, develop and implement a written quality assurance program. This program shall include a system of on-going review of at least a representative sample of IEPs developed or modified in the facilities to monitor quality and assure compliance with the requirements of the ADJC policy and the IDEA.
Status: Partial compliance
Discussion: The QA Team during this second reporting period is reviewing IEPs, documentation for service delivery, and the status of MET
Recommendation: During the next reporting period, the ADJC education program should review the quality assurance activities with the Consultants' Committee.
Documentation: Observation of a QA review at RAC at Adobe Mtn. School, discussion with Dr. Lanphar, Education Superintendent, discussion with Dr. Megan McGlynn, Director of Quality Assurance, ADJC, review of QA draft policies.

6. MEDICAL CARE

UFN 6.1 The state shall ensure that youth in these facilities receive adequate, appropriate and timely (a) Medical, (b) Dental, and (c) Nursing care to meet the individual needs of the youth.
UFN 6.1 (a) Medical
Status (a): Substantial Compliance for Medical Care

Discussion (a): The Consultants Committee reviewed information regarding the need for development of an infectious disease committee. The pediatric care has continued in a consistent fashion as was described in the discussion on the March 15, 2005 first semiannual report.

The Consultants Committee reviewed information regarding the need for development of an infectious disease committee. Dr. Raker informed the Consultants Committee that a committee has been developed. The purpose of this committee includes assessing such things as infectious disease issues, immunizations, infectious disease outbreaks, and sexually transmitted disease testing

Mr. Lafond has continued with consistent supervision by Dr. Raker. There was a brief break in supervision secondary to illness, but overall supervision has occurred consistently.

There have been several changes. Dr. Raker is now the primary physician at the Adobe facility and Brenda Vold, RN-C is responsible for medical care at the Black Canyon School facility. This allows a female practitioner to be involved in the majority of female care.

There were concerns in the initial CRIPA investigation that the oxygen tanks were not filled with oxygen at the Adobe Mountain facility. At the time of my most recent assessment, the oxygen tanks at all three facilities were full.

Recommendations:

1. Clear documentation of procedures and implementation regarding quality assurance should continue.
2. Continued documentation of the infectious disease committee and ongoing meetings, which address infectious disease issues should continue.
3. There needs to be continued documentation regarding logs and patient discussion notebooks regarding supervision of Mr. Lafond. There should be consistency with Dr. Raker going to the Catalina School at least once every two weeks, if not weekly, for assessment of the medical facility and supervision of Mr. Lafond onsite.

Documentation: Interviews with Dr. Raker and Mr. Lafond, reviewing numerous charts, review of collateral information including the continuous quality improvement program procedures No. 3000.06 and CCHC Essential Standard Y-A-06, page 10. Consent for Medical, Dental, Surgical, Psychiatric and Psychological services procedure No. 3100.22 transportation of juveniles to and from outside referrals. Procedure No. 3100.04 Right to Refuse Health Care. FY 2006 FT allocation summary dated July 18, 2005 Policy 1005.2.03 Quality Assurance Medical Monitoring and Quality Improvements effective 7-15-05. . A letter from Dr. Raker to Dean Neitzke dated May 19, 2004 regarding defibrillators was reviewed. All of the documents available for the first semiannual report of March 15, 2005 should also be included. The Consultants Committee met with Dr. Raker on two occasions and with Mr. Lafond, CMS, PA.

UFN 6.1 (b) Dental

Status (b): Substantial Compliance

Discussion: Deficits in the initial CRIPA evaluation were primarily related to not having a

consulting dentist at the Catalina Mountain School. In the initial evaluation, none of the dentists were reviewed. The Consultants Committee met with William Gillespie, DDS, MHA. Dr. Gillespie is the dental administrator and has also developed a quality improvement program for dental. He reported that Dr. Brian Seek is the dentist at Adobe and works 40 hours per week. Dr. Gillespie works 20 hours per week at Eagle Point and his other 20 hours is administrative. He reported that Edward Sparks, works 10 hours per week at Catalina, 5 hours per week on Wednesday and 5 hours on Fridays and that Dr. William Gioia works 5 hours twice a week, totaling 10 hours at Black Canyon School. Dr. Gillespie reported that he has a dental database for the last six years. However, all of the information which Dr. Gillespie gave was consistent and supportive of compliancy with the CRIPA agreement. Dr. Gillespie is also responsible for quality assurance.

Dr. Gillespie reported that he makes periodic site visits. He reported that they have attempted to follow the ADA requirements regarding general dentistry. He reported that typically the adolescents who are being treated are being treated as adults as their permanent teeth are already in place. He reported that they have once a year evaluations and that every child is evaluated. Dr. Gillespie reported that he continues to attempt to improve the dental services by seeking to provide services beyond the requirements of the CRIPA agreement, by instituting preventive dentistry practices. In summary, the only area of concern with dental with the initial CRIPA evaluation had to do with there not being a consulting dentist at Catalina. At the present time there is a consulting dentist at Catalina and as such this problem has been resolved.

Recommendations 1) There should be a continued focus in maintaining a full complement of dental staff. 2) Consultants Committee encourages the Department to consider the preventative dentistry measures that Dr. Gillespie is exploring.

Documentation: The Consultants Committee reviewed protocols and summaries regarding dental services, interviewed Dr. Gillespie and were shown documentation regarding consulting dentists at all facilities.

UFN 6.1 (c): Nursing Care

Status (c): Partial Compliance

Discussion: Implementation of quality assurance has begun for nursing which is consistent in all three facilities. Youth were observed receiving nursing care at all three facilities. Facilities, such as Catalina, which is understaffed, reported that there are certain aspects of nursing care which they have not been able to implement, such as patient education. They have focused mostly on medication disbursement and more acute medical issues. There has been improvement in security in the health units; most of the time on the day shift security is in nursing when youth are being assessed. Other issues regarding staff shortages will be discussed in Section 6.2. Catalina has filled their nursing supervisor position.

Recommendations: All attempts should continue to be made to have a full staffing of nurses. The Department should continue to implement its quality assurance program.

Documentation: Nursing staff including Kevin Harper, BSN, RN, from Black Canyon, Mr. West, the new nurse manager at the Catalina School and the nurse manager from Adobe Mountain School were all interviewed. Prior documentation from the first semi-annual report was reviewed. Charts were reviewed, the nursing receiving screening form was reviewed, and the quality assurance form was reviewed. The quality assurance review from the Black Canyon School, March of 2005 audit was reviewed.

UFN 6.2. The state shall ensure there is a sufficient number of adequately trained nursing staff on all shifts to provide medical and nursing care to youth as needed. If, despite the states good faith effort to recruit and retain nursing staff, nursing shortages significantly impedes substantial compliance with the paragraph, the state may utilize a sufficient number of adequately trained paramedics, as necessary, to provide medical coverage during the overnight shifts at the facilities.

Status: Partial Compliance

Discussion: The Department has made a significant effort to hire new staff. However, due to a nursing shortage there continue to be openings. Catalina Mountain had four nursing vacancies at the time of the Consultants Committee visit and was experiencing difficulty recruiting for them. At BCS there are currently nine full time nursing positions, including two newly established overnight FTE nursing positions. There were four vacancies, including the two new positions, at the time of the Consultants' visit. Adobe Mountain had one position vacant at the time of the Committee's visit. All three facilities have budgeted nighttime positions so that there will be 24-hour nursing at each facility. The process of structuring infirmary care is still in discussion.

At present, the concept of whether there will be one central infirmary or, an infirmary at each institution is still in discussion. The Department currently transports youth in need of continuous care to area hospitals.

At Adobe a new medical/nursing building is being constructed which physically can house an infirmary. The Black Canyon and Catalina facilities have space which can be used as an infirmary. As such, minimal, if any, additional structural changes will be needed.

Infirmary care would require 24 hour nursing. Admission to or discharge from an infirmary requires a physician's order. Health records for the youth should be easily accessible. Infirmary care requires minimally daily monitoring. Infirmaries are designed for those youth requiring skilled nursing care and those who cannot be medically managed safely in the cottages.

A number of available nursing positions will eventually allow for 24-hour, 7-day a week nursing coverage at all three institutions. With the current vacancies, the primary focus was to take care of any medication distribution, acute emergency and when possible to assist the physician, physician assistant and psychiatrist and attend to any medical emergencies that arose. Safety issues regarding the transfer of youth to the medical unit have improved. On the day shift at all three facilities, more often than not, security is available and with the youth when they are in the medical facility. All of the nurses which the Consultants Committee spoke with felt that this was a vast improvement and offered a level of safety for them. They continue to acknowledge that

later in the day, there is no security. However, they reported that there are far fewer youth who come to nursing during that time and when possible they will try to see the youth in the dorm.

Due to relative nursing shortages, there continues to be concern over a lack of patient education regarding the medications that they are on. There are no policies in place or procedures observed where nurses attempt to explain to the youth the potential side effects of the medication or review with the youth regarding issues of side effects. At the Black Canyon facility there is now a planned attempt for improved levels of confidentiality in handing out medication.

Human resource is reportedly running ads to the local newspapers and a budget request for eight new nursing positions has been approved by the legislature and governor.

Recommendations: 1) Continued efforts should be made to fill any open nursing hours. If these cannot be filled, there should be further review of why this is the case and a significant attempt to ameliorate this problem. 2) The Department should determine how it intends to provide services to youth who are ill, recuperating from injury or otherwise, may be in need of infirmary care. Ideally, there would be an infirmary at each institution. This needs to be resolved in the next reporting period. At present, recruitment for 24-hour nursing has reportedly been put into place. However, these nurses have not yet been hired. The justification for 24-hour nursing includes the care of children who are sicklier, the care of children with infectious disease, the care of children who have just recently returned from the hospital who may have significant medical needs, external fixators or other medical issues which should be handled by nurses. In addition, there is also the possibility that a child will be placed in restraints on the night shift. A nurse should be present for that as well.

Documentation: Interviews with the nurse supervisors at Black Canyon, Adobe and Catalina Mountain School. Interviews with Dr. Kellie Warren, Dean Neitzke, and Dianne Gadow. Reviewing the nursing quality assurance review, a 2-page, 22-item review, a review of charts, procedure 3000.08, organization of health records policy, a medical summary sheet and other medical record related sheets, including a SOAP note, an ambulatory healthcare report. Policies reviewed included 3000.01, 3000.05, 3000.06, 3000.15, 3000.16, 3100.05 3100.09, 3100.12 and 3100.26.

UFN 6.3 The state shall continue to implement a nursing quality assurance process, including audits of medical charts, and medication administration records to monitor nursing assessments, care and documentation where problematic, trends are identified, the state shall timely develop, implement and monitor a corrective action plan.

Status: Substantial Compliance

Discussion: As described in UFN 6.2 discussion, a 22-item quality assurance review is being used at all three facilities for nursing. However, the amount of time that this has been occurring is unclear. All three supervisory nurses reported that they have been pulling out 10 charts per month which have been undergoing the quality assurance process. The Consultants Committee has been informed by all three nurses that this has been working consistently and has been helpful.

<p>The Consultants Committee has not yet reviewed the process of how problematic trends are identified or how the state will develop in a timely way, implement and monitor a corrective action plan. However, the policies and initial protocols are being implemented at all three facilities. Initially, the staff reported that they were beginning talks with the National Commission on Correctional Health Care. At present, the Consultants Committee was informed that ADJC will not formally work with the National Commission until all policies are in place.</p>
<p>Recommendations: 1) The policies and procedures regarding quality assurance for nursing needs to be followed in a consistent pattern. 2) When problematic trends are identified, development and monitoring of a corrective plan needs to occur in accordance with the Department's quality assurance policy.. 3) Follow up with the NCCHC as was stated to the Consultants Committee initially would occur is expected to occur.</p>
<p>Documentation: Interviews included Dr. Warren, Dean Neitzke, all three supervisory nurses, and Dr. Megan McGlynn. Documents reviewed included the new quality assurance form for nursing, relevant policies including 3100.17 and youth charts.</p>
<p>UFN 6.4 The state shall develop and implement a formal system for the pharmacist to document alerts to the physicians regarding information about any youth's medication issues.</p>
<p>Status: Substantial Compliance</p>
<p>Discussion: The initial concerns regarding the pharmacists had to do with no active pharmacy and therapeutics (P&T) committee. There were additional concerns regarding the medication box not being evaluated and looked at in approximately six months and issues of medications within the box not being documented and at least one medication having expired.</p> <p>The Consultants Committee again met with the pharmacist, Dr. Dennis Haag. Dr. Haag is continuing to do a tremendous job. He has continued with consistent P&T committees, the medication boxes are being assessed and are up to date. He is continuing to look at the current formulary based on medications being requested and has updated. He informed me that there has not been any medication requested, whether on or not on the formulary that has not been available to a youth. In addition, Dr. Haag reported that there is now a system in place which can alert the ADJC practitioner's regarding any youth's medication issues. This is also documented in the P&T committee minutes.</p> <p>Regarding quality assurance, the pharmacy office will maintain a written log documenting all alerts shared with the medical staff. Additionally, the pharmacy alerts/issues will be summarized for review during the quarterly pharmacy and therapeutic committee meetings. Dennis Haag also reviewed this information with me and stated that this is occurring in a consistent fashion.</p>
<p>Recommendation: None</p>
<p>Documentation: Interviews with Dr. Kellie Warren, Dennis Haag, Dean Neitzke. Review of policy 3101.02. Review of the P&T Committee minutes and the current ADJC formulary.</p>

7. MENTAL HEALTH CARE

UFN 7.1 The state shall ensure that adequate mental health care and treatment services are provided to youth in the facilities.

Status: Partial Compliance

Discussion: A mental health outline has been developed. The discussion within these outlines will be referred to in the remaining components of Section 7.

I. Initial Intake Screening:

A. Timely medical care to meet the individuals needs. The majority of intake screening is done through the RAC unit at the Adobe Mountain School. The initial screening is done in a timely fashion . Within one hour of the youth arriving to the facility they are given several initial intake screenings, including the Criminogenic and Protective Factors Assessment (CAPFA). One hundred percent of youth coming into the institution are given this assessment. In addition, they are given the MAYSI and the SASSI (for substance abuse issues). At the present time. Dr. Gold reported that 96 percent of the children at the facility have a history of substance use and as such, everybody is receiving a SASSI. A Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV) and a Woodcock Johnson to further assess educational needs will be performed at the initial assessment through psychology and education. At the present time, there are two psych associates assisting with the evaluations in the RAC program, one is from the Enterprise Dorm and the other from the Challenger Dorm. RAC is still waiting for two new psych associates to assist with this process. The interview process takes about four hours. The psych associates reported that at the present time they are not clear regarding referrals for cognitive testing and have reported that at present this is not occurring.

Tom Seymour, Ph. D., has been placed in charge of mental health services. Dr. Seymour currently is filling in for a psychology vacancy in the RAC unit. At the present time, he reported that he is just in the process of acclimating to the RAC unit and has not had a significant amount of hands-on involvement. Dr. Seymour and Dr. Gold reviewed components of the CAPFA with me. The four most relevant areas of the CAPFA include the behavioral health domain, the psychiatric aggression domain, the attitude and behavior domain and the alcohol and drug domain. At the present time, the psychologist signs off on the behavioral health domain, but the psych associate signs off on the other three. If a particular medical issue is identified the youth is referred to pediatrician for further follow-up. Based on my discussions with the pediatrician and the review of a number of charts, this has appeared to occur in a timely and efficient manner.

B. Screening Tools and Processes

- **Identification of Suicidal youth** – Initial identification of suicidal youth will be through an initial interview which will include giving of the CAPFA and MAYSI assessments.
- **Identification of Youth with Substance Abuse Problems** – 96 percent of youth entering Arizona Department of Juvenile Corrections have a history of some substance

abuse. As such, basically all the children are considered potentially to have substance abuse problems. Nonetheless, as part of the initial intake, the children are given the SASSI. This is a validated assessment to further address potential substance abuse issues. One of the identified difficulties at the present time is that each facility has only one cottage which focuses on substance abuse and even within these facilities there have been mental health staffing shortages. As such, although many of the youth have been identified with a history of substance abuse, interventions have not been consistently been put into place.

- **Identification of Youth with Cognitive and Learning Disorders** – The Consultants Committee was informed by Dianne Gadow that the plan on the initial assessment within the RAC unit will be to have a representative from psychology give youth the Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV), unless there is a Wechsler Abbreviated Scale of Intelligence (WASI) and or a WISC-IV assessment for the youth that is less than a year old.. Education will further assess achievement (mathematics, reading and written expression) by giving a Woodcock Johnson to every youth. At the present time this was not started. The staff within the RAC unit were not aware of how this would be implemented and have not been informed about this yet.
- **Identification of Youth Taking Psychotropic Medication or Otherwise Needing Referral to Psychiatry** - The behavioral health domain of the CAPFA is signed off by the psychologist. A decision regarding referral recommendations is reportedly made at that time. In speaking with both psychiatrists at Adobe, as well as the treating psychiatrist at the Black Canyon School and in reviewing numerous charts, follow-up on referrals occurs in a timely fashion, basically, seeing the youth the next time they are in the facility. Additional mental health screening to assist with the referrals include the MAYSI and SASSI. There is a plan to revise the mental health referral policy, both to psychologists and psychiatrists for those youth that are exhibiting mental health problems, but do not yet have current mental health diagnoses or are not yet on medications. This policy and planned summary are not yet in place, based on the information reviewed. Those youth who are currently taking psychotropic medications are referred in a timely manner to psychiatry. Dr. Wherry, who had been a primary contact for psychiatry, resigned her position as psychiatrist at BCS, and at the time of this writing, the position had not been filled.
- **Identification of Youth with Other Behavioral, Educational, and Mental Health Needs** – Initial identification will occur at the RAC screening in association with a clinical interview with implementation of the CAPFA, MAYSI and SASSI assessment. There will be four psych associates and one psychologist within the RAC unit. Currently they have two psych associates and are awaiting two additional psych associates and are still interviewing for the psychology position.

C . Staffing and Training/Qualifications of Staff Conducting Screening:

There have been significant amounts of training. Staff has had CAPFA classroom training with clear identification of those individuals who have had the four-hour CAPFA follow-up training; 198 individuals completed the initial CAPFA assessment and 185 individuals did the four-hour CAPFA follow-up. Currently there are only five individuals within the institution left to complete the CAPFA follow-up training. There has been a significant focus on staff training and reassessing staff qualifications regarding those conducting screenings.

II. Timely Referrals for Mental Health and Psychiatric Assessment Post-Intake

UFN 7.33, 7.331, 7.332, 7.333, 7.3.3.4: The action plan is to revise mental health referral policy for those youth on psychotropic medication. The process should ensure that juveniles on psychotropic medication receive adequate psychiatric follow-up. Specific policies regarding timely referrals and the process of these timely referrals regarding communication between a qualified mental health professional and the psychiatrist or an initial evaluator and either mental health or psychiatrist still remain somewhat vague. Based on my discussions with the psych associates, psychologists and psychiatrists, the referrals are being made in a timely manner but there is no specific policy which treaters are following. In assessing mental health charts, youth are consistently seen in a timely manner.

III. Assessments:

A. Psychiatric: Psychiatric assessments should occur in a timely manner. There needs to be clear policy regarding the timeframe when a youth initially comes to the institution on psychotropic medications and when they are seen by the psychiatrist. Assuming that they are not unstable, 48 to 72 hours appears reasonable. There also needs to be a clear policy regarding referral to a psychiatrist for a youth with acute or chronic mental health issues who may not be on psychotropic medications. These procedures remain in draft form (7.3.3.1 – 7.3.3.4). The psychiatric assessment should include review of collateral information, discussion with the psych associate or psychologist involved in treatment for the youth for clarification of the referral question. Significant attempts at communication with the family regarding the psychiatric history, requests for psychiatric material including prior discharge summaries and psychiatric or psychological assessments if they are not part of the youth's file. The Academy of Child and Adolescent Psychiatry recommends two hours for a comprehensive psychiatric assessment. This is variable, depending on the child.

The customary amount of time for a new assessment is typically at least one and a half hours, plus the additional time needed for collateral contacts and review of collateral information. The Consultants Committee would recommend a clear structure to the psychiatric assessments following a biopsychosocial framework with a focus on the acute behavioral issues, psychiatric diagnoses, and treatment plan with clear goals. Informed consent must be obtained in accordance with Arizona law. Documentation of Informed Consent must be on the chart. Clear goals of treatment, side effects of any psychotropic medications need to be documented, either in the material sent to the parent or specific documentation if one so chooses. The Consultants Committee would recommend that initial psychiatric assessments be typed so as to assist with the ability to read them and so they can be more easily used in treatment planning meetings, hospitalizations, transition meetings, etc.

Overall, psychiatric assessment at all three facilities has been consistent and comprehensive. There is a need for better attempts and follow through with collateral contacts and development of clear procedures for obtaining informed consent.

B. Psychological/Psych Associate: The psychologist and psych associates who are completing initial assessments on youth need to use the information available through CAPFA, the MAYSI, and SASSI assessments for their initial assessments. They need to review available

collateral information and conduct a comprehensive clinical evaluation with a defined mental status exam, preliminary diagnoses, and recommendations for treatment, referrals, and treatment goals.

- C. Substance Abuse:** Initial substance abuse assessments should be completed through the RAC. This will be initially completed through implementation of the MAYSI and SASSI assessments. At the present time, the Consultants Committee has been informed that 96 percent of the youth at the Arizona Department of Juvenile Corrections have a history of substance use and may be in need of treatment on some level. The Consultants Committee would strongly recommend that the psychologist at the RAC assess this particular issue and make a determination of the treatment plan for each child regarding alcohol and substance abuse. It would likely make the most sense that this be part of the psychologist/psych associate assessment.
- D. Cognitive:** As was described in our meeting with Ms. Gadow and others, cognitive assessment will occur at the RAC through education. This will include all youth being given a Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV), unless they have received one or a Wechsler Abbreviated Scale of Intelligence (WASI) within one year, and a Woodcock Johnson Achievement Test to assess educational achievement. This will be a tremendous accomplishment when achieved.
- E. Suicide Risk Assessments:** Initial suicide risk assessments through the RAC will be accomplished through clinical interview and assessment of the CAPFA and MAYSI. Newly hired direct care medical and mental health staff will receive additional training on suicide prevention to assist with effective intervention and identification of youth who are suicidal.
- F. Emergency Mental Health Assessments** (e.g., sexual assault, acute loss, suicidal threat, etc.) Regarding issues of physical or sexual assault there will be an obvious medical assessment as per ADJC policy, such as Policy No. 3100.18 (alleged sexual assault within a secure facility). This includes a facility psychologist being available to evaluate the juvenile for a mental status examination. 1) At the present time, based on the information reviewed and discussion with staff, there is no consistent clear mental health assessment in place. For example, development of a process where a psychiatrist evaluates a child in acute need requiring hospitalization is still being worked on. 2) Other than the psychologists or their designee seeing an acute sexual assault victim, there are no additional descriptions regarding the role of the evaluation. In the Consultants Committee opinion, psychiatry should also be involved with that assessment. 3) There is no clear policy regarding enforced medication at times of psychiatric emergency.

In addition to a psych associate or psychologist taking a clear history, there needs to be clear policy regarding the examination and documentation to the extent of physical injury by the pediatrician and a clear determination whether or not a referral to a medical facility is indicated. With the victim's consent, the examination includes the collection of evidence from the victim, using a kit approved by the local legal authority. Prophylactic equipment, including emergency contraception consistent with the state law, the regulations of the jurisdiction of follow-up care for sexually transmitted or other communicable diseases are

offered to all victims as appropriate. A report is made to the correctional authorities to effect a separation of the victim from his/her assailant in the housing assignments. Assessment of the adolescent victim for potential for suicide and/or anxiety disorders or other mental health problems is completed. Treatment plans must also take into understanding the cultural competency and language issues.

IV. Comprehensive Treatment Planning:

A – B: Interdisciplinary Plan Content (Specific content requirements identified in UFN 7.3.6.1; 7.3.6.1-9.). **C) Cultural competency and language considerations. D) Transition to the community.** (Psychiatry, psychology/psych associates, medical, education, social work). Treatment plans have specific content which need to include: the treatment plan to be individualized (7.3.6.1), the identification of the mental and/or behavioral health issues to be addressed, a description of any medication or medical course of action to be pursued (7.3.6.2, including the initiation of psychotropic medication (7.3.6.3), a description of planned activities (interventions to monitor the efficacy of any medication or the possibility of side effects) (7.3.6.4), a description of any medical behavior plan or strategies to be undertaken (7.3.6.5), a description of any counseling or psychotherapy to be provided (7.3.6.6), a determination of whether the type of level of treatment needed can be provided in the youth's current placement (7.3.6.7), a plan for monitoring the course of treatment (7.3.6.8). and development of a transition plan for when the youth leaves the care of the state, which shall include providing the youth and his/her parents/guardian with information regarding mental health resources available in the youth's home community; making referrals to such services when appropriate; and providing assistance in making initial appointments with service providers (7.3.6.9).

Policies regarding interdisciplinary treatment planning have been put into place starting 4-25-05. Treatment plans themselves have not yet been implemented.

Treatment plans must also take into understanding cultural competency and language issues. There are interpreters available for Spanish speaking families and youth in each of the facilities. There is a relative paucity of culturally competent and bilingual therapists. Policies for appropriate treatment plans are in place. They have not yet been clinically implemented.

V. Mental Health Treatment

A. Counseling/Therapy services: When evaluating the Catalina School on 6-24-05 there were no mental health workers, no psychiatrists, no physician assistant, and only one registry nurse at the facility. Other medical staff were receiving motivational training that day.

Each facility continues to have openings for psychology associates. This decreases the likelihood of youth being seen consistently who are in need of therapeutic treatment. New forms to assess how many youth are being seen by individual psych associates have been developed. Until there is a full complement of psych associates and psychologists at the facilities seeing youth consistently, this will not occur. The psych associates and psychologists interviewed appeared confident to complete the roles defined. The exception is that within some of these specialized units such as the substance abuse treatment unit at Catalina, there has not been a psych associate with alcohol and substance abuse treatment

certification in place to assist in treatment of the youth. Treatment should be consistent with what is determined within the treatment plan and the needs of the youth. The Consultants Committee was also informed by Ms.Gadow that the primary focus at the present time had been on completing the intake protocols and that they are still in need of hiring additional mental health professionals and that for this evaluation there should not be an expectation that there had been any improvement regarding mental health services.

Goals and measurements of success need to be developed regarding target symptoms and assessment of these symptoms following set periods of time. At the present time, there are no clear measurements regarding goals and success of treatment.

- B. Substance abuse treatment services:** Each facility has one substance abuse treatment unit. These units have not been consistently staffed with at least one psych associate who has certification in substance abuse treatment. The Consultants Committee was informed by Dr. Gold that Adobe now has a certified substance abuse treater in their program. The Catalina facility has a staff member with certification, but this person is not involved in the clinical aspect of the program. The Black Canyon facility does not have a certified substance abuse counselor in their program.

As has been described, 96 percent of youth report some substance use. Alcohol and substance abuse trained and certified therapists should be a priority. There should be continuation of focused treatment units as has occurred with appropriately trained staff in each of the facilities. In addition, there needs to be additional alcohol and substance abuse treatment within all of the dorms.

- C. Behavioral intervention staffing and training/qualifications of staff providing counseling/therapy services:** There continues to be a blurring between mental health interventions and non-mental health interventions regarding behavioral interventions. For example, non-mental health interventions could include cottage management issues, and follow through with the point system.

Mental health interventions regarding behavioral management will include more complicated behavioral interventions with the youth, often in association with dynamic and other cognitive approaches. Therapeutic groups should be run by a qualified mental health professional such as a psych associate, psychologist or a psychiatrist. If one had advanced practice nurses they would also be included in that group. At the present time, likely due to the deficit in psych associates and psychology positions, it is important to clearly demarcate the role of mental health and the role of non-mental health staff. Non-mental health staff should not be responsible for direct mental health interventions. The Department needs to differentiate between the groups that must be conducted by qualified mental health professionals and the groups that can be conducted by other staff.

VI. Psychotropic medication management:

- A. Appropriateness of prescribed medications and dosages:** Charts were reviewed from all of the prescribing psychiatrists. In the opinion of the Consultants Committee prescribed medication and dosages were appropriate for the symptoms being treated.

B. Monitoring of medications being administered:

- a. Lab work protocols: There are new draft procedures regarding lab work protocols. These are in the process of being followed by all of the treating psychiatrists. Overall, the Consultants Committee saw no deficits regarding lab works being ordered for the medications which youth were on.
- b. Side effect monitoring (e.g., AIMS): Side effect monitoring has primarily been focused on clinical assessment of side effects for example assessing whether there are extrapyramidal side effect or signs of tardive dyskinesia. Overall, it is the opinion of the Consultants Committee that there has been appropriate assessment of these. However, the Consultants Committee suggests that this could be more clearly documented. In addition, using standardized assessments such as the AIMS would be of assistance with this.

C. Documentation/charting: The Consultants Committee reviewed charting from all current psychiatrists within the Arizona Department of Juvenile Corrections. Overall, charting was readable and consistent; signatures were legible. When collateral information was used this was substantiated in the chart. There was inconsistency regarding the initial psychiatric assessment and its placement in the charts. For some, they were handwritten and for others they had been typed by the psychiatrist, or they had access to a transcriber. The Consultants Committee would recommend that the initial assessment be typed and comprehensive as has previously been described in this outline.

D. Informed consent: The Consultants Committee reviewed charts from all of the current psychiatrists. All of the psychiatrists reported that they make attempts to reach parents or guardians regarding informed consent and then document this. There was some documentation that attempts were made. More often than not when documentation that informed consent was obtained, there was no clarification of what specifically was reviewed with the parents regarding goals and side effects of the medication. More often than not when an informed consent couldn't be obtained by the physician it was given to the nurse to obtain the informed consent. None of the nurses interviewed at any of the three facilities could review specific goals and side effects of psychotropic medications. None of them had specific updated child and adolescent psychopharmacology reference books to assist them with this process.

It is the opinion of the Consultants Committee that most of the parents had likely been contacted on some level. However, based on the review of charts, the information reviewed with the parents regarding goals and side effects remains deficient.

E. Staffing and training/qualifications of psychiatric staff: At the time when the Consultants Committee was interviewing, the goal was to increase psychiatric services at the Catalina program from .5 to 1.0 FTE. At the present time, that position had not been filled. The prior .5 FTE psychiatrist at the Black Canyon facility had quit and Dr. Wherry 1.0 FTE psychiatrist primarily working at the Black Canyon facility had given her letter of resignation. This resulted in no clear psychiatric oversight and by August of 2005, there were no identified psychiatric services at the Black Canyon School. Although it is reasonable

to think that there have been consistent attempts made for services, this has not been sent to the Consultants Committee as of August 15, 2005.

Minimally, psychiatrists should be board certified in adult psychiatry with significant experience in treating adolescents. The Consultants Committee would recommend that within ADJC that there is at least one board certified child and adolescent psychiatrist. At the present time, there is one .5 FTE child and adolescent psychiatrist who is not board certified.

VII. Crisis Management:

A. Use of restraints: Based on the Consultants Committee interviews at all three facilities, restraints are rarely used, but recently have appeared to be used more frequently. This is potentially due to staff turnover, potentially the mix of youth who are coming to the facilities (that they are more significantly mentally ill), or perhaps some other reason.

The Consultants Committee understands that nursing coverage will be provided 24 hours per day. As such, nursing should be assessing vitals and assessing the youth once they have been placed in restraints for any morbidity. This is best when the psychiatrist can be contacted prior to the youth being placed in restraint. When they are placed in restraint it would be the Consultants Committee's recommendations that the psychiatrist is contacted within one hour and are able to assess the child within two hours if they are still in restraints. Specific national protocols continue to be variable. Many hospital settings and states still require a one-hour rule (where a physician has to evaluate a child in restraint within one hour). Due to the difficulty of independent hospitals being able to follow through with this and the cost for on call psychiatrists, many hospitals use their emergency room physician or other physicians who may be on call for that initial assessment. Any MD for the service can initially assess the child. Ideally it should be a psychiatrist. Having a psychiatrist or other physician on call would likely add some additional cost, but in the Consultants Committee's opinion the coverage is needed if one is going to use restraints.

All staff that use restraints on youth must be trained in the proper applications. There has been much discussion regarding the use of supine four-point restraint, versus a sitting restraint. After review of available literature, it is the opinion of the Consultants Committee that there are no identified significant differences in morbidity or mortality in the chair versus a supine restraint.

In the rare instance when a juvenile would be restrained beyond one hour, exercising each limb for at least 10 minutes every 2 hours is recommended to prevent blood clots.

There must be performance measures which include no new injuries, comparison of the previous year, expressed number of occurrences, trends in these occurrences, and ultimate outcomes. The National Commission of Correctional Health Care recommends that every 15 minutes a health trained personnel health service staff check any patient placed in clinically ordered restraints and that the checks are documented. Currently the protocols in Arizona require 30-minute checks. One child that was assessed at the Black Canyon facility was not assessed for 60 minutes.

If a restrained juvenile has any medical or mental health condition the physician must report this to mental health or medical staff.

- B. Separation:** Separation is the terminology in the ADJC to describe removal from the youth's treatment unit. Exclusion is the term used for short term removal from the program when a youth remains on the unit. The NCCHC definition of a segregated juvenile are those isolated from the general population and who receive services and activities apart from other juveniles. There is a concern that youth that are placed on separation on multiple occasions will have a much higher likelihood of having underlying mental health issues and be at higher risk for a suicide attempt. Currently ADJD policy requires monitoring of youth based on level of separation. During the next reporting period the use of separation as a cottage management tool and the implications for mental health concerns will be more fully addressed.

If for any reason, out of control behavior lasts for more than 24-hours the youth must be evaluated by a psych associate, psychologist or psychiatrist. ADJC provides for this. Documentation reviewed on separation reflects that this has occurred consistently.

Obviously, youth that are placed on separation for mental health issues will have more intensive mental health assessment during this process. During the Consultants Committee review at the Black Canyon facility there was at least one example where a youth was on separation for mental health issues, where there was poor communication between the psychiatrist, nursing, the psych associate, and psychologist involved. Staff did not know whether or not PRN medication had been given emergently; they were unsure whether there was any procedure regarding this issue and there were significant delays in hospitalization.

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C. Hospitalization of Youth:

- a. Timeliness:
- b. Assessment:
- c. Follow-up care

The terminology, psychiatric hospitalization, implies that a psychiatrist needs to be involved with this process. Psychiatric hospitalization should occur in a timely fashion. When a youth is identified as needing hospitalization every attempt should be made within a 24-hour period. However, the Department has no control over when, or if, a hospital accepts such a youth for admission. At the present time, based on 4 different youth who have recently been hospitalized, this has not occurred. On two of the youth, hospitalization has taken up to a week if not longer. When the Department has difficulty securing a mental health bed for such a youth, it must take every precaution to ensure the youth's safety in the institution. When one thinks about the issue of safety it is not just regarding suicide risk, but also morbidity such as cutting, head banging, etc.

Arizona law provides that the assessment for hospitalization should be completed by a psychiatrist, psychologist or a non-psychiatrist physician.. The initial assessment and assistance regarding hospitalization should be completed through psychology/psych

associates in as timely a fashion as possible, a follow up psychiatric assessment and when indicated, assistance from psychiatry such as “doc-to-doc” conversation with the hospital should also occur.

Transitions from the hospital are quite important. The ADJC has done a very good job in transitioning youth back from hospitalizations. Often transition meetings over the phone are held. These meetings are extensive reviewing what has occurred in the hospital and post hospital recommendations. Youth are seen in a timely fashion when they return from the hospital, both from the psychiatrist and their psych associate or psychologist.

7.1 Documentation: Articles reviewed include the First Semiannual Report dated March 15, 2005, the Quality Assurance Review form. A variety of medical records, notes, separation log reports, the petition for hospitalization of a youth, a variety of emails, UFN projection status for Section 7, CRIPA UFN action plan transmittal forms for UFN 7.31, 7.32, 7.33, 7.3.3.1, 7.3.3.2, 7.3.3.3, 7.3.3.4, 7.3.3.5, 7.3.3.6, 7.3.3.1 through 7.3.6.9, 7.3.7, the training calendar for behavioral health services for ADJC, CV for Gary Kramer, Procedural Guidelines for administering mental health and substance use screening and assessment instruments dated January 10, 2005, a fax from Traci Wherry to Kelly Warren dated 5-20-05, Policy 4250 Counseling Suicide Prevention effective 4-6-05, Memorandum dated June 21, 2005 regarding 24-hour nursing schedules, CMS close observation assignment, incident report tracking log for CMS from 6-1-05 to 6-21-05, Assault Injury Report from May of 2005, scheduling description for the different health units and what posts are needed to be filled, Procedure 1120.07 Maintenance of the Mental Health Record draft, different position description questionnaires, resume for Susan Kaz, Psy. D., resume for Thomas Seymour, Ph. D., resume of William Jenkins, Ph.D., resume for Bonnie Milan, Ph.D., examples of the Quality Assurance Review, review of Maintenance of Mental Health Records, emails from Mariann Picardo, MD. Policy No. 4064 regarding security exclusion describes issues of removal and exclusion and concern over issues such as suicide prevention
Policy No. 4064 regarding security exclusion describes issues of removal and exclusion and concern over issues such as suicide prevention. Policy No. 4064 regarding security exclusion describes issues of removal and exclusion and concern over issues such as suicide prevention

UFN 7.2

- a. The state shall ensure a deputy director who shall meet minimum standards as specified by the state, to oversee the mental health care and rehabilitative care of youth at the facilities.
- b. The state shall provide the deputy director with sufficient staff and resources to perform the tasks required by this agreement, including:

Status: a) Substantial Compliance; b) Partial Compliance

Discussion: Consistent with the first semiannual report, Diane Gadow, Deputy Director of the Arizona Department of Juvenile Corrections continues to oversee mental healthcare and rehabilitative youth at the facilities. Please refer to UFN 7.1 regarding the partial compliance status in part b. Most significantly, there continued to be deficits in staff, both in nursing and mental health.

<p>Recommendations:</p> <p>Particular effort needs to be focused on hiring approved staff. There continued to be a concern regarding the number of openings, both in nursing and mental health. Currently there are 1.5 FTE positions open in psychiatry and an additional .5FTE for psychiatry of a new position at CMS which will need to be filled.</p>
<p>UFN 7.2.1 Oversight of mental health care in the facilities, including monitoring the performance of psychologists and private psychiatric contractors, and the development and implementation of policies and training.</p>
<p>UFN 7.2.2 Monitoring whether staff for resources are sufficient to provide knowledgeable mental health care and rehabilitative treatment services to the facility youth and to ensure compliance with this agreement.</p>
<p>Status: Substantial Compliance</p>
<p>Discussion: An organizational chart with clear reporting lines has been put into place. Thomas Seymour, Ph.D. has been placed in charge of mental health services. See UFN 7.1. However, Dr. Wherry has recently resigned. The Consultants Committee was informed that Dr. Seymour will now oversee psychiatry. Clear documentation regarding how this will occur should be presented prior to the next semiannual report. Policies and protocols have been implemented and the reporting supervisory lines have been made clear.</p>
<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Follow through with the lines of communication that have been established in the policy. 2. The Consultants Committee would recommend more cohesively structuring how psychiatry is going to be supervised and how the supervisor of psychiatry, whether a psychiatrist or a psychologist will take responsibility over this. At the present time this is not in place.
<p>Documentation: See UFN 7.1 Documentation Section.</p>
<p>UFN 7.2.3 Development and implementation of a Quality Assurance Program for mental health care in coordination with the quality assurance team.</p>
<p>Status: Partial Compliance</p>
<p>Discussion: See UFN 7.1 Section 8 Quality Assurance</p>
<p>Recommendations:</p> <ol style="list-style-type: none"> 1. Clear procedures regarding mental health and psychiatric quality assurance need to be in place 2. Implementation of quality assurance for mental health needs to be consistently implemented.

UFN 7.3 Intake Screening and Assessment:
UFN 7.3.1 The Deputy Director shall continue to develop and utilize policies and screening instruments for qualified mental health professionals to conduct proper intake screenings at each facility as soon as practicable upon the youth's admission. When no such professional is on site to conduct the screening, it shall be conducted by another staff member who has received specific training in conducting such assessments. The staff member shall, as soon as is practicable, then contact a qualified mental health professional and confer. A psychiatrist or psychologist shall review and sign the mental health needs assessment.
Status: Substantial Compliance
Discussion: See UFN 7.1 No. 1, A,B, C and No. 2.
Recommendations: <ol style="list-style-type: none"> 1. Fill all open psych and psychology positions as soon as possible. 2. Assessment programming needs to be used appropriately. For example, follow the University of Massachusetts protocols regarding the implementation of the MAYSI and clearly document the procedure. 3. Policies regarding timely referrals for mental health and psychiatry shall be clearly documented. 4. Further discussion of ways to potentially unify the intake so that it all occurs at the RAC.
Documentation: Refer to UFN 7.1 Documentation Section
UFN 7.3.2 The Deputy Director shall issue policies and procedures to assure appropriate action when an intake screening indicates that a youth is taking or prior to admission may have been prescribed, psychotropic medications. This shall include appropriate steps to contact the prescribing psychiatrists when necessary and referral to the facility psychiatrist for evaluation.
Status: Substantial Compliance
Discussion: UFN 7.1 Section 2 and Section 3 Part A.
Recommendations: <p>The draft procedures need to be put in a formal policy and procedure and implementation needs to be started prior to completion of the next assessment, otherwise 7.3.2 will not be in substantial compliance.</p>
Documentation: See UFN 7.1 Documentation Section
UFN 7.3.3 The Deputy Director shall develop and implement policies and procedures for referral of youth for mental health evaluations based on the results of a mental health and suicide risk screening or a mental health needs assessment, other referrals from staff or the conduct of the youth during the course of confinement at the facility. These procedures shall require referrals

when: 7.3.3.1 A youth's mental health poses a risk of physical harm to him/herself or others if the youth has been diagnosed as mentally ill.
Status: Substantial Compliance
UFN 7.3.3.2 The youth exhibits mental health problems but does not have a current mental health diagnosis from a psychologist or psychiatrist.
Status: Partial Compliance
UFN 7.3.3.3 The youth is determined to be taking psychotropic medication, or has taken them in the past.
Status: Partial Compliance
UFN 7.3.3.4 The youth requires a change of medication prescribed as a result of any mental health condition.
Status: Substantial Compliance
Discussion 7.3.3.1; 7.3.3.2; 7.3.3.3; 7.3.3.4 Please refer to 7.1 Section 2, Section 3.
Recommendations: <ol style="list-style-type: none"> 1. It is the Consultants Committee recommendation that a psychiatrist should make the final assessment of youth prior to hospitalization and make those specific recommendations. 2. The Consultants Committee would strongly recommend using an MD in assisting with that decision process. Having this assessment will help with follow-up and discharge planning. 3. The draft procedures for referrals to psychiatry and mental health need to be formalized and implemented as soon as possible.
Documentation: Please refer to UFN 7.1 Documentation Section
UFN 7.3.4 The deputy director shall if a need for mental health treatment is indicated ensure the youth receive the treatment indicated.
Status: Substantial Compliance
Discussion: Kelly Warren, Psy. D., has continued to provide consistent restructuring, development of policies and procedures and monitoring of youth needing mental health treatment and attempting to ensure that this occurs, even when those policies may not yet exist or are in draft form. Her efforts regarding this are commendable. Please refer to UFN 7.1, all sections regarding this process.

<p>Recommendation:</p> <ol style="list-style-type: none"> 1. There is still a need for structured procedures to be formalized. 2. All procedures need to be implemented. 3. Open mental health staff positions and psychiatric positions need to be hired as soon as possible. 4. There needs to be clear policy and procedures regarding the use of enforced medications. 5. Structured protocols for youth going into separation need to be better assessed regarding youth going both to a separation unit as well as a youth placed on separation within their dorms. Once a youth is pulled from their activities it is considered separation or exclusion and the protocols for each of these should be consistent. In addition, the youth that have required repeated separations or extended lengths of time with separation should have comprehensive mental health assessments, including a psychiatric assessment.
<p>Documentation: See UFN 7.1 Documentation Section</p>
<p>UFN 7.3.5 Each youth receiving psychotropic medication or otherwise in need of mental health treatment shall have a treatment plan in accordance with professional standards of practice. The treatment plan shall be developed by a treatment team pursuant to policies developed by the deputy director, which shall include the identification of the required members of the treatment team.</p>
<p>Status: Partial Compliance</p>
<p>Discussion: See UFN 7.1 Section 4</p>
<p>Recommendations:</p> <ol style="list-style-type: none"> 1. MDT procedures have been revised and approved and signed by the director on 5-6-2005. However, they have not yet been implemented. 2. The comprehensive interdisciplinary treatment planning now needs to be implemented in a consistent fashion. 3. Family interventions and cultural competency with a particular focus on transition to the community will continue to be an important part of this process and will be looked at closely when assessing implementation.
<p>Documentation: Please refer to UFN 7.1 Documentation Section</p>

<p>UFN 7.3.6 The Deputy Director shall develop and implement policies and procedures for the required content of treatment plans which shall include:</p> <ul style="list-style-type: none"> 7.3.6.1 That the treatment plan be individualized; 7.3.6.2 An identification of the mental and/or behavioral health issues to be addressed; 7.3.6.3. A description of any medication or medical course of action to be pursued, including the initiation of psychotropic medication; 7.3.6.4 A description of planned activities to monitor the efficacy of any medication or the possibility of any side effects; 7.3.6.5 A description of any behavioral management plan or strategies to be undertaken; 7.3.6.6 A description of any counseling or psychotherapy to be provided; 7.3.6.7 A determination of whether the type or level of treatment needed can be provided in the youth's current placement; 7.3.6.8 A plan for monitoring the course of treatment; and 7.3.6.9 A transition plan for when the youth leaves the care of the State, which shall include providing the youth and his or her parents or guardian with information regarding mental health resources available in the youth's home community; making referrals to such services when appropriate; and providing assistance in making initial appointments with service providers. However, nothing in this Agreement shall make ADJC responsible for providing mental health services to youth no longer in the custody of the State.
<p>Status: 7.3.6.1 Partial Compliance; 7.3.6.2 Substantial Compliance; 7.3.6.3 Substantial Compliance; 7.3.6.4 Substantial Compliance; 7.3.6.5 Partial Compliance; 7.3.6.6 Partial Compliance; 7.3.6.7 Partial Compliance; 7.3.6.8 Partial Compliance; 7.3.6.9 Partial Compliance</p>
<p>Discussion: Refer to UFN 7.1 Section 4, Section 6, Sections a and b and Section 8</p>
<p>Recommendations:</p> <ul style="list-style-type: none"> 1. Implementation of transition planning. 2. Better case management should be implemented. 3. Appointments must be set up before the 10-day supply of medication is gone. 4. The transition plan should involve the multidisciplinary treatment plan. 5. If the psychiatrist cannot make the meetings, his recommendations need to be submitted in writing. 6. The school program should be involved with this as well.
<p>Documentation: See UFN 7.1 Documentation Section</p>
<p>UFN 7.3.7 The Deputy Director shall issue and implement policies and procedures for the admission of appropriate tests (including for example, blood tests, EKG's, and abnormal and involuntary movement scale test) to monitor the efficacy and any side effects of psychotropic medications in accordance with professional standards.</p>
<p>Status: Partial Compliance</p>
<p>Discussion: See UFN 7.1 Section 6, Section A and B</p>

Recommendations:

1. Final procedures for lab work need to be developed. Dr. Kraus will assist with this process as requested.
2. When starting a child on a psychotropic medication, particularly if their symptomatology is significant, a follow-up within one week and some level of communication with the psych associate during that time is recommended.
3. Clear informed consent needs to be given both to the youth and his guardian. The specific information given and what was reviewed should be documented. If a particular handout were given, documentation regarding what handout was given and how it was explained should be recorded.

Documentation: UFN7.1 Documentation Section

Appendix A: CPS Memorandum



MEMORANDUM

DATE: August 2, 2005

TO: Dianne Gadow, Deputy Director

FROM: John Dempsey, Administrator I&I

SUBJECT: Synopsis of Meeting with CPS

On July 26, 2005 I&I Administrator, Deputy Director Gadow, I&I Investigations Commander and the QA Administrator met with CPS Program Administrator Janice Mickens, Program Manager Carla Conradt to discuss ADJC reporting requirements to CPS. Also present was an attorney from the AG's Office. ADJC Was advised of the following:

1. CPS adheres to a strict interpretation of ARS 13-3620 as it pertains to required reporting of Child Abuse crimes-that is that the statute is satisfied by these allegations that occur within ADJC jurisdiction are reported to Inspection sand Investigations-of which AZPOST police officers are members thereof.

13-3620. Duty to report abuse, physical injury, neglect and denial or deprivation of medical or surgical care or nourishment of minors; medical records; exception; violation; classification; definitions

A. Any person who reasonably believes that a minor is or has been the victim of physical injury, abuse, child abuse, a reportable offense or neglect that appears to have been inflicted on the minor by other than accidental means or that is not explained by the available medical history as being accidental in nature or who reasonably believes there has been a denial or deprivation of necessary medical treatment or surgical care or nourishment with the intent to cause or allow the death of an infant who is protected under section 36-2281 shall immediately report or cause reports to be made of this information **to a peace officer or to child protective services** in the department of economic security, **except if the report concerns a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only.** *(ADJC does not have legal custody of the youth adjudicated to*

them-that legal custody still resides with the parent/guardian and/or if the youth is a ward of the State-CPS)

F. Any person other than one required to report or cause reports to be made under subsection A of this section who reasonably believes that a minor is or has been a victim of abuse, child abuse, physical injury, a reportable offense or neglect may report the information to a peace officer or to child protective services in the department of economic security, except if the report concerns **a person who does not have care, custody or control of the minor, the report shall be made to a peace officer only.** *(According to the CPS Attorney General, ADJC does not have legal custody of the youth adjudicated to them. That legal custody still resides with the parent/guardian and/or if the youth is a ward of the State-CPS).*

2. Staff members alleged to have committed crimes contained within this statute against a youth adjudicated to ADJC, **will not be reported to the CPS Hot-line.** The reason for such is that CPS investigates only those cases in where an individual has care, custody or control over a youth and commits crime contained in this statute. The investigation of allegations will be processed as any other criminal investigation is conducted by I&I.
3. Professional licensure requirements (Doctors, Teachers, Mental Health providers) of reporting suspected child abuse/neglect are satisfied under this statute with notifications to I&I- (police officer).
4. If a youth, who is a ward of the State, is involved in any incident and/or need permission for medical services ADJC staff will contact CPS as any parent would be. A policy in draft has been written and is in review addressing such.
5. If a youth is transitioning back to the community from an ADJC facility, and ADJC staff does not believe the home of the child is an appropriate placement- (the parent not taking care of the youth)- the staff can contact CPS, who in turn will investigate and take action if necessitated.

Arizona Department of Economic Security, Division of Children, Youth and Families CPS Representatives

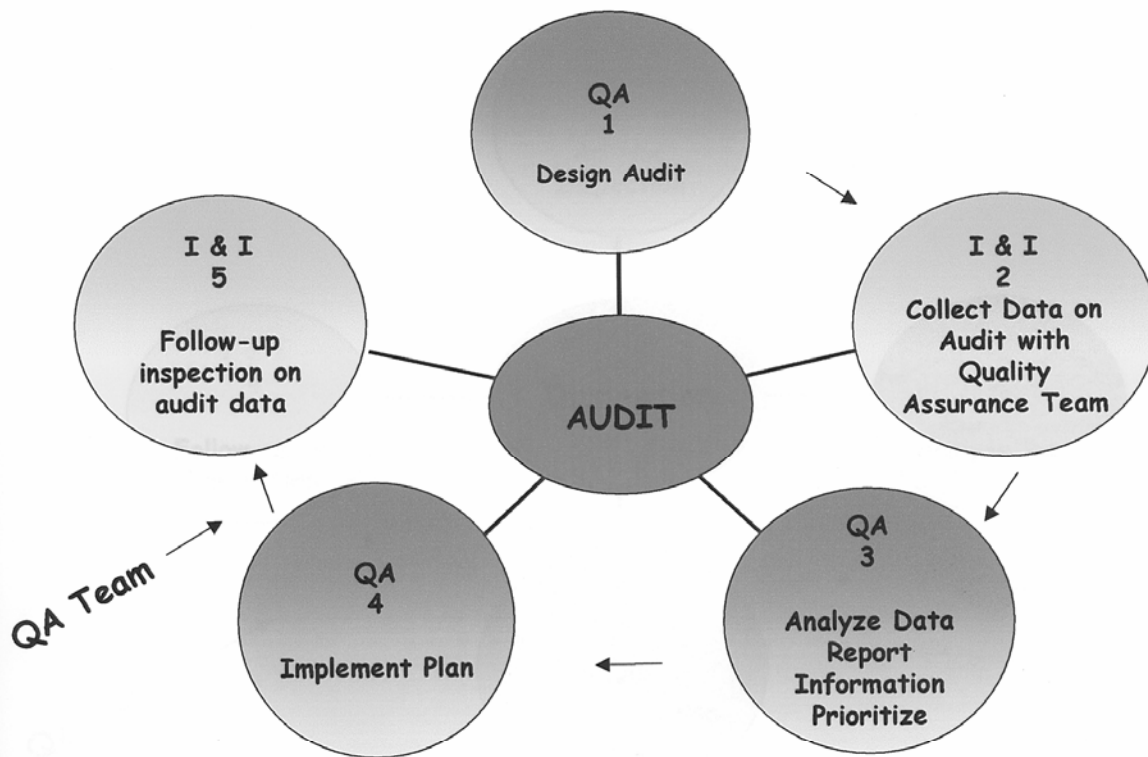
Janice A. Mickens, Program Administrator

Phone (602) 542-2275

Carla M. Conradt, Program Manager, Arizona Child Abuse Hotline
530-1825


Phone, (602)

Appendix B: Quality Assurance Inspections and Investigations Activity Flow



Agency Quality Assurance Activity Flow

Appendix C: Exclusion Policy

	Policy: Chapter: Rule:	4064 Security Exclusion	Effective: Replaces: Dated:	06/15/2005 4064 10/10/2000
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A.R.S.		A.C.A Standard
§§41-2804		3-JTS-3C- 02,06.07,08,10,: 3e- 01,02,04

The Arizona Department of Juvenile Corrections (ADJC) is committed to employing a range of behavior management techniques to provide a safe and therapeutic environment and to teach juveniles pro-social decision making and problem solving skills. The brief removal of a juvenile from regular programming and contact from other juveniles, i.e. Exclusion, is one technique.

	Michael D. Branham, Director

Definitions:

1. **Exclusion:**
 - a. The removal of one or more juveniles from regular programming and contact from other juveniles between waking and regularly scheduled bed time-hours by requiring the juvenile(s) to remain in a specified location such as hallways and locked or unlocked juvenile rooms.
 - b. Anytime these conditions exist (including shift change, transition periods, early bed times, etc), juveniles are considered to be on exclusion and shall be managed in accordance with this policy.
 - c. The confinement of juveniles to their rooms during an authorized large group is not exclusion and shall be conducted in accordance with Procedure 4220.04 Large Group Protocol – Secure Facilities.
 - d. The confinement of juveniles in their room during an emergency such as a 1024 in the Housing Unit or facility lockdown during activation of the Emergency Management System is not exclusion and shall be conducted in accordance with Procedure 4007.06 Lockdown (Secure Confinement) Limitations.

2. **Standard Entrance Level Supervision:**
 - a. The procedure of observing and documenting a juvenile's activities at staggered intervals not to exceed 15 minutes, in accordance with Procedure 4250.02 Suicide Prevention.